



Solicitation Information

February 18, 2013

LOI#: 7461250

TITLE: Coordinating Care Entity for Connect Care Choice *Community Partners* Program under the Medicaid Integrated Care Initiative

Submission Deadline: April 2, 2013 @ 10:00 AM (EST)

Questions concerning this solicitation must be received by the Division of Purchases at David.Francis@purchasing.ri.gov no later than **March 14, 2013 @ 12:00 AM Midnight (EST)**. Questions should be submitted in a *Microsoft Word* attachment. Please reference the RFP# 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 RIVP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

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CHAPTER ONE: GENERAL STATE REQUIREMENTS AND INSTRUCTIONS

This chapter includes general State requirements and notifications for interested parties to follow in preparing proposal submissions to assist the Executive Offices of Health and Human Services (EOHHS) administer the Connect Care Choice *Community Partners* Program (CCCCP). The Connect Care Choice *Community Partners* program is a major component of the Medicaid Integrated Care Initiative (ICC) to serve Rhode Island Medicaid adult populations including those individuals who are receiving long-term care services (institutional and home/community-based care) and those individuals who are Medicare beneficiaries and are eligible for full Medicaid benefits.

This Letter of Interest (LOI) is directed at organizations or companies to serve as a Coordinating Care Entity (CCE). The CCE functions are six fold: (1) Enroll members in the CCCCCP program and provide member & provider services; (2) Conduct an analytic risk assessment and an Initial Telephonic Health Screen to assess member needs for care management services; (3) Establish an Community Health Team and to serve as a Lead Care Manager for members requiring non-medical social or “peer mentoring” services; (4) Comply with the principles of ICC and the requirements of the CCCCCP program (such as a person- centered system, development of a comprehensive Plan of Care to meet member needs, a multi-disciplinary provider team, an integrated and coordinated delivery of medical, behavioral health and LTSS); (5) Provide support to EOHHS for members who have transitioned from the Nursing Home Transition Program and the *Rhode to Home* demonstration grant to the CCCCCP program (by reporting critical incidences and developing Emergency Back-Up Plan and ensuring the capacity to meet member emergency needs) ; and (6) Provide EOHHS operational data reports on CCCCCP member and program activities.

This is a Letter of Interest and not a Request for Proposal (RFP) or an Invitation to Bid (ITB). 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 a Model Contract and the capitation rates, appended to this LOI. There shall be no public opening and reading of responses received by the State of Rhode Island, other than the names of bidders who have submitted proposals.

The following indicates the conditions associated with the LOI.

1.1 Issuing Agency and Officer

The Rhode Island Department of Administration/Office of Purchases, on behalf of the Executive Office of Health and Human Services (EOHHS), is soliciting Technical Proposals from qualified bidders to coordinate medically or functionally necessary services to eligible Medicaid recipients through a managed care program under a capitation contract. EOHHS is the issuing agency for this LOI. The Administrator of Purchasing, as noted on the LOI Cover Sheet, shall serve as the sole point of contact for this LOI. This LOI and any subsequent award(s) are governed by the State’s **General Conditions of Purchase** (available at www.purchasing.ri.gov).

1.2 General Instructions and Notifications to Bidders

The following provides general instructions and notifications to potential respondents to this LOI:

- Potential Bidders are advised to review the Rhode Island's General Conditions of Purchase for contractors available at www.purchasing.ri.gov.
- Potential Bidders are advised to review all sections of this LOI carefully and to follow the instructions completely, as failure to make complete submission as described elsewhere herein may result in rejection of the proposal.
- 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 the work defined in this LOI will be rejected as being non-responsive.
- All costs associated with developing and submitting a proposal in response to this LOI or to provide oral or written clarification of its content shall be borne by the Bidder. The State assumes no responsibility for any costs associated with preparing the proposals.
- Proposals are considered to be irrevocable for a period of not less than one hundred twenty (120) days following the opening date, and may not be withdrawn, without the express written permission of the State Purchasing Agent.
- 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 purpose of this requirement, the official time and date shall be that of the time clock in the reception area of the Division
- It is intended that an award pursuant to this LOI shall be made to one primary contractor, who will assume overall responsibility for the provision of the Integrated Care Initiative – Connect Care Choice *Community Partners* program. Joint ventures and cooperative proposals shall not be considered. Subcontracts are permitted, provided their use is clearly indicated in the vendor's proposal, and the subcontractor(s) to be used are identified in the proposal.
- Interested parties should be aware that all materials associated with this LOI are subject to the terms of the Freedom of Information Act, the Privacy Act, and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, U.S. Department of Health and Human Services (HHS), and CMS.
- Interested parties are advised that all materials, except for proprietary information, submitted to the State for consideration in response to this LOI shall be considered to be

Public Records as defined in Title 38, Chapter Two of the Rhode Island General Laws, without exception, and will be released for inspection immediately upon request.

- In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporations, 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.
- The State reserves the right not to enter into a contract with any interested party of this procurement if the proposals do not respond to State's needs, at the time of review. The State also reserves the right to make use of all ideas contained in the submission, whether future procurements are issued or not, or whether future contracts are awarded or not.
- 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.
- Interested parties shall be aware of Rhode Island's Minority Business Enterprise (MBE) requirements and the State's goal of achieving ten percent participation by MBE's in all State procurements. For further information, contact the MBE Administrator at (401) 574-8253 or visit the web site at www.mbe.ri.org or contact cnewton@gw.doa.state.ri.us.
- Proposals shall contain a completed and signed three-page RIVIP Certification Form and a completed and signed W-9 Form (taxpayer identification number and certification). These forms may be downloaded at www.purchasing.ri.us.
- The purchase of services under an award pursuant to this LOI will be contingent on the availability of funds.
- Interested parties submitting a proposal shall register on-line at the State Purchasing website at www.purchasing.ri.us.
- American Recovery and Reinvestment Act of 2009 (ARRA) Supplemental Terms and Conditions. For contracts and sub-awards funded in whole or in part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto, such contracts and sub-awards shall be subject to the Supplemental Terms and Conditions for Contracts and Sub-awards Funded in Whole or in Part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto located on the Division of Purchases website at www.purchasing.ri.us.
- The State reserves the right to amend this LOI at any time with respect to the implementation of Federal Health Reform (Patient Protection and Affordable Care Act-PPACA).

1.3 Confidentiality and Protection of Public Health Information and Related Data

The successful Bidder is required to execute a Business Associate Agreement, Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, shall require the successful bidder to comply with 45 C.F.R. § 164.502(e), 164.504(e), 164.410, governing Protected Health Information (“PHI”) and Business Associate under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated there under, and as amended from time to time, the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations there under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, R.I. General Laws, Section 5-37.3 et.seq.

The successful Bidder shall be required to ensure, in-writing, that any agent including a subcontractor, to whom it provides Protected Health Information received from, or created or received by and/or through this contract, agrees to the same restrictions and conditions that apply through the above described Agreements with respect to such information.

1.4 Code of Ethics and Professional Behavior

It is the policy of the State of Rhode Island that public officials and employees will adhere to the highest standard of ethical conduct; respect the public trust and rights of all persons; be open, accountable, and responsive; avoid the appearance of impropriety; and not use their positions for private gain or advantage.

No person subject to the code of ethics will have any interest, financial or otherwise, direct or indirect; engage in any business, employment, transaction, or professional activity; or incur any obligation of any nature which is in substantial conflict with the proper discharge of his/her duties or employment in the public interest and of his/her responsibilities, as prescribed in the laws of this State.

No person subject to the code of ethics will accept other employment, which will either impair his/her independence of judgment as to his/her official duties or employment or require him/her, or induce him/her, to disclose confidential information acquired by him/her in the course of, and by reason of, his/her official duties.

No person subject to the code of ethics will willfully and knowingly disclose, for pecuniary gain, to any other person, confidential information acquired by him/her in the course of, and by reason of, his/her official duties or employment or use any such information for the purpose of pecuniary gain.

No person subject to the code of ethics will use, in any way, his/her public office or confidential information received through his/her holding any public office to obtain financial gain, other than that provided by law, for himself/herself or spouse (if not estranged) or any dependent child or business associate, or any business by which said person is employed or which said person represents.

No person subject to this code of ethics, or spouse (if not estranged), or dependent child, or

business associate of such person, or any business by which said person is employed or which such person represents, will solicit or accept any gift, loan, political contribution, reward, or promise of future employment based on any understanding that the vote, official action, or judgment of said person would be influenced thereby.

No person will give or offer to any person covered by this code of ethics, or to any candidate for public office, or to any spouse (if not estranged), or dependent child, or business associated of such person, or any business by which said person is employed or which such person represents, any gift, loan, political contribution, reward, or promise of future employment based on any understanding that the vote, official action, or judgment of said person would be influenced thereby.

In accordance with regulations pursuant to Title 37, Chapter Two, the State's Chief Purchasing Officer is authorized to investigate and resolve conflicts, including, but not limited to, the following measures: (1) reassignment of the State employee involved, (2) termination of the State employee involved, (3) debarment of any/all vendors involved.

CHAPTER TWO: BACKGROUND

The Executive Offices of Health and Human Services (EOHHS), is the designated single state agency for Medicaid in the State. There are five State Departments and Divisions that expend Medicaid funds: The Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); The Department of Children, Youth and Families (DCYF); the Department of Human Services Division of Elderly Affairs (DEA); and the Department of Health (DOH). EOHHS accounted for seventy-five percent of the expenditures and BHDDH accounted for twenty-two percent.

This chapter provides potential bidders background information about the Rhode Island Medicaid program and the reasons for this procurement.

2.1 Rhode Island Medicaid Program

The Medicaid Program is a principal source of health care coverage and services in Rhode Island. The Rhode Island 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, having served approximately one-third of the State's population within the last five years. It is now an integral part of the State's health care delivery system, serving over 224,000 Rhode Islanders in SFY 2011, at a cost of \$1.824 billion dollars. Medicaid expenditures make up approximately 25 percent of the State's budget.

Between SFY 2006 and 2010, total Medicaid medical expenses based on the date of service has increased 2.5 percent per year. This increase is based on a 2.5 percent increase in per-member-per-month (PMPM) cost and a zero percent increase in enrollment, which considered together determines the average expenditure growth. These expenditure trends compare favorably to both national Medicaid expenditures and state commercial insurance cost trends.

The expenditures for each major population group for SFY 2011 are noted below:

- **Adults with disabilities:** account for the largest share of expenditures (38 percent and \$702 million) at an average PMPM of \$1,997 and represent 16 percent of the Medicaid population. The major source of expenditures for this population is residential and rehabilitation services for the developmentally disabled (28 percent) and hospital care (26 percent).
- **Elders:** represent nine percent of the Medicaid population and account for 26 percent of Medicaid expenditures (\$475 million). Elders have the highest average PMPM cost of \$2,257. Nursing facilities account for roughly two-thirds of the expenditures.
- **Children and families:** represent 68 percent of the total enrollment and account for 26 percent of the total expenditures (\$462 million). Average PMPM for Children and families is \$ 322.04.

- **Children with special health care needs (CSHCN):** is a relatively small population (seven percent of the recipients) and account for 10 percent of the expenditures (\$179 million). The average PMPM for this population is \$ 900.41.

Thus elders and adults with disabilities represent 22 percent of the Medicaid recipients and account for 64 percent of the expenditures. Seventy-seven percent of the Medicaid population is enrolled in a Health Plan and accounts for 48 percent of Medicaid expenditures. (In part this is because the vast majority of managed care enrollees are in the RItE Care program, which has a lower PMPM cost, than the elder or adult disabled populations).

Hospitals and nursing homes account for nearly 48 percent of all program expenditures. (Hospitals account for 29 percent and nursing homes account for 19 percent of the expenditures). 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. Medicaid expenditures are highly concentrated. The top seven percent of Medicaid recipients account for over two-thirds of the expenditures. The average cost associated with these 16,188 recipients was \$68,708 per person.

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 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 a payer to an active purchaser of care. Central to this has been a focus on improved access and quality along with cost management as core program objectives. Contracting with “accountable” entities provides a structure for measuring and enforcing performance standards. The state has been able to leverage the capabilities of Managed Care Organizations (Health Plans) and the Primary Care Case Management (PCCM) program (in such areas as network capacity, member services, care management and coordination) while maintaining a strong oversight role.

The State’s initial Medicaid managed care program, RItE Care, began in 1994, enrolling over 70,000 low income children and families. A key contractual element was the “mainstreaming” provision, requiring that Health Plans must ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RItE Care enrollees without discrimination. The number of providers participating in RItE Care Health Plans networks represented marked expansion over fee-for-service, with primary care provider participation more than doubling. Physician visits more than doubled by June 1998. In November 1998 RItE Care expanded to families with children under 18 including parents and relative caretakers with incomes up to 185 percent of FPL; and in 1999 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, 200 beneficiaries are enrolled in the State's fully integrated 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 PACE organization service area. 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, Rhode Island Medicaid, and The PACE Organization of Rhode Island (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. Currently, there are 1701 individuals enrolled in the program.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for persons with disabilities. In the fall of 2009, all Medicaid eligible "aged blind and disabled" (ABD) adults without third-party coverage who resided in the community were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC). Currently there are 13,577 enrolled in the Rhody Health Partners Program.

This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the contractual requirements of Health Plans have also expanded in terms of program requirements and in covered benefits, as the state has increased the performance requirements of Health Plans for managing the health care needs of complex populations. Health Plans were not required, however, to pay for home and community-based services but did pay for 30 days of nursing home stays.

Appendix A is a Data Book that provides additional information on the Medicaid populations affected by this procurement.

Currently, there are two Health Plans participating in the RI managed care programs: (1) Neighborhood Health Plan of Rhode Island (NHPRI), and (2) UnitedHealthcare Community Plan (United). The total enrollment in both of these Health Plans for the RItE Care and Rhody Health Partners (RHP) program was 139,379 on September 30, 2012. Table 1 below indicates managed care enrollment for the Medicaid recipients by Health Plan.

Table 1: Managed Care Program Enrollment (as of September 30, 2012)

PROGRAM	NHPRI	UNITED	TOTAL
Rite Care	85,858	40,233	126,091
Rhody Health Partners	6,287	7,001	13,288
TOTAL	92,145	47,234	139,379

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 2011)

PROGRAM	EXPENDITURES
Rite Care	\$447.2 Million
Rhody Health Partners	\$199.7 Million
TOTAL	\$646.9 Million

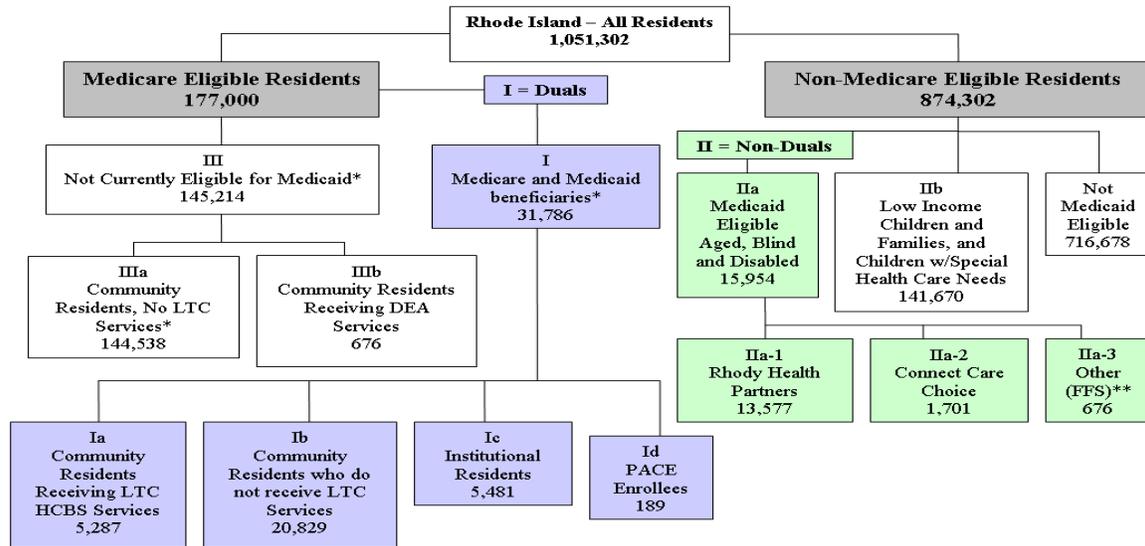
Currently there are seventeen Connect Care Choice practice sites statewide. In SFY 2011, the Connect Care Choice program enrollment totaled 2,015 members. The total SFY 2011 expenditures for the Connect Care Choice program were \$43,790,391 million.¹

2.3 Medicare Medicaid Eligible Population

Table 3 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).

¹ ACEMedicaidExpense 20120808.xls

Table 3: The Rhode Island Medicaid Population (SFY 2011)



* Note that in SFY 2011 there were 3,527 Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB) and Qualified Individuals (QI) beneficiaries not eligible for full Medicaid benefits for whom Medicaid pays only a Medicare premium plus the patient share (for QMBs) of Medicare services. These individuals are included in III and IIIa, above. In addition, there were 4,031 Medicare and Medicaid Eligibles (MMEs) who were enrolled in Medicare Advantage plans in SFY 2011.

** Includes members who are either in institutions or have non-Medicare third party coverage.

Sources: 2010 US Census, Kaiser State Health Facts, 2011 data. Medicaid data are based on SFY 2011 figures.

Note that the Medicaid figures presented in Table 3 are averages per day during SFY 2011.

Over the course of twelve months the number of unique individuals in any of these categories is larger.

Over seventeen (17) percent of Rhode Islanders are Medicare beneficiaries (i.e. 177,000 Medicare beneficiaries out of a total population of 1,051,302). That is not surprising since fourteen (14) percent of the State’s population is 65 years old or over. Rhode Island has the fifteenth (15th) largest proportion of elder residents in the nation. The current elder population is expected to increase by twenty-one (21) percent from the current 154,541 to 247,000 individuals by 2030.

Over seventeen (17) percent or 31,786 (i.e. average eligible) of Medicare beneficiaries are also eligible for the Medicaid program. The group is commonly referred to as “Dual-Eligible” or “Medicare and Medicaid Eligible (MME)”. The number of residents who are eligible (i.e. average eligible) for Medicaid is 189,410 (i.e. Boxes I, IIa and IIb).

The MME population presents many challenges. Individuals in this group often have more complex medical conditions, greater functional impairments, are more socially isolated, are less educated, suffer from cognitive impairments and are more costly to serve. As previously indicated there are 27,622 MME individuals in Rhode Island who are eligible for full Medicaid benefits. The total Medicare and Medicaid cost of serving these individuals is \$931.4 million (\$292.8 million for Medicare funding and \$ 638.6 million of Medicaid funding).

In SFY 2011, the MME members represented 16 percent of the total Medicaid population and accounted for Medicaid expenditures of \$638.6 million. Medicaid-only adults with disabilities represented 9 percent of the population with expenditures totaling \$309 million. Combined, these two groups account for 25 percent of beneficiaries and at \$1.087 billion, approximately 59 percent of total Medicaid expenditures. Currently, 21 percent of the dual population is in an institutional long-term care setting which accounts for 74 percent of total expenditures for the dual population. Approximately, 14 percent of the MME population is enrolled in a Medicare Advantage Plan (MAP).

Residential and long-term care expenditures for institutional and waiver services constitute over 94 percent of the Medicaid cost for MME members. By contrast, 63 percent of the expenditures for the Medicaid-only members 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.

Medicare benefits emphasize medical interventions that are expected to restore the health status or functioning of the individuals. Consequently, most Medicare costs are contained in acute expenditures. For the majority of Medicare members, the coverage is adequate. However, as health status becomes more complex or deteriorates, Medicare’s coverage frequently becomes too limited. Medicare does not cover custodial services provided in long-term care settings or home and community-based services. The lack of coverage for the latter set of services for adults with developmental disabilities, many of whom will require such care on a continuous basis, typically brings Medicaid eligibility early on as an adult, usually as part of the transition from youth-based programs. By contrast, for elders and other adults with disabilities, it is an adverse health event that creates the need for the non-Medicare covered services. At such points, Medicaid becomes the payer for the wide array of critical services and supports needed across both institutional and community-based settings. The Data Book found in Appendix A provides additional information on the population covered under this procurement.

The Medicare and Medicaid programs were not designed to work together. Both programs operate separately and distinctly, leading to a fragmented financing system for providers who serve people on both programs, and uncoordinated care for the consumer. By design, Medicare funds primary, specialty, and acute care while Medicaid funds predominately long-term services and supports, including nursing home admissions. The impact of the fragmentation becomes

most evident at critical moments when a MME beneficiary is transitioning from one care setting to another. For example, when a MME client is discharged from a hospital to home, the discharge planning conducted at the hospital (Medicare funded) is often not well coordinated with the care plan for supports in the home (Medicaid funded) upon discharge. Few incentives, resources, or mechanisms for care coordination exist in the current FFS system.

There are three critical issues related to the current system that need to be addressed to improve the services to the dual population and to control costs:

- **Improve Coordination of Care.** Without the proper coordination and discharge planning, MME individuals are vulnerable to emergency department visits, readmissions to the hospital and nursing home stays that are potentially avoidable or longer than necessary. MME individuals do not currently benefit from a coordinated and integrated care team. This can result in unmet needs or improper utilization of the health care system. The integration of Medicare and Medicaid funding streams will lead to more seamless care delivery and improve the quality of care, and access to care for beneficiaries covered by both programs.
- **Align Financial and Quality Incentives.** A longstanding barrier to coordinating care for MME individuals has been the financial misalignment between Medicare and Medicaid and the conflicting requirements for payers, providers, and beneficiaries. The financial incentives are not currently aligned to promote coordination between the two programs. This fragmentation has led to inefficiencies in the way care is paid for, the way providers render care, and the way beneficiaries access their care.
- **Improve System Navigation.** The Medicare and Medicaid programs not only cover different benefits, but also have different administrative procedures and rules in place. These dichotomies leave MME individuals to navigate a bifurcated system of benefits and rules with limited assistance and no single place for members and their caregivers to direct questions regarding their benefits, their provider networks, etc. Providers are often thrust into the role of care coordinator, spending an inordinate amount of time determining which program to seek prior approval from to deliver services, which program to submit claims to, and which program to appeal to, if a provider does not agree with a benefit decision. Among other advantages, an integrated system would allow members 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 Rhode Island to develop new approaches for improving the access, coordination and quality of care in a more cost-effective manner.

2.4 Long-Term Care

What is critical to the State is the number of individuals who receive or who are at-risk of requiring long-term services and supports (LTSS) and become potential future Medicaid recipients. For example, as indicated in Table 3, 676 Medicare beneficiaries receive LTSS through the Division of Elderly Affairs (DEA) because their current income or assets are above

Medicaid standards (as indicated in Box IIIb). While 15,960 full benefit MME individuals presently reside in the community without home and community-based services (Box Ib), approximately 2,551 of them are persons with severe and persistent mental illness (SPMI). Also it is estimated that within this group of community-based MME individuals upward of ten percent are at increased risk for needing home and community based supports within two years, based on historical utilization patterns. As indicated in Table 3, 5,286 MMEs are presently receiving Home and Community Based Services (HCBS) to help maintain their ability to continue living in the community (Box Ia). It is estimated that 2,324 are individuals with functional limitations and developmental disabilities. Additionally, there are 5,481 duals living in an institutional setting on an average day (Box Ic). It is estimated that a total of 9,000 recipients are in an institutional setting on any given day. It is further estimated that seventy-five percent of those recipients are institutional residents for nine or more months. There are 189 individuals enrolled in the PACE program. Of the 15,000 Medicare only aged, blind and disabled adults, it is estimated that at least one-third will become MME within two years of obtaining Medicaid eligibility.

In State Fiscal Year (SFY) 2011, Medicaid long-term care expenditures for services provided by EOHHS were \$ 423.5 million. Institutional care expenditures were \$279.5 million or 86 percent and HCBS were \$82.8 million or 14 percent. RI has a significantly higher rate of utilization of nursing homes than the national average, with 56 nursing home residents per 1,000 individuals, as compared to 38 nursing home residents per 1,000 individuals nationally. RI ranked fourth in the nation in the proportion of overall population that spent ninety days or more in a nursing home. In addition, RI nursing home residents are less impaired and have a lower severity of need than the national average. The high use of nursing homes, longer stays and the lower acuity levels of need provides RI with a significant opportunity to provide long-term services in a community-based setting, which is less costly and often more desirable to consumers.

Access to and the availability of long-term care services and supports is a critical issue in Rhode Island. Long-term care services are particularly critical for the frail elderly, children and youth who are involved in the child protective and criminal justice systems, and adults with disabilities, including developmental disabilities. All too often, these individuals are served in an institutional rather than in a community-based setting. RI has been committed to and is working on improving the availability of options for those requiring long-term care for a number of years now. Some of the most salient initiatives include:

- The creation of a 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, to conduct 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 included: provisions for nursing home savings reinvested in home and community-based services, uniform long term care provider cost reports, improved information and referral, streamlined identification and assessments, and increases for specific home and community-based providers.
- In 2006, RI was awarded the Real Choice System Transformation Grant to improve Information and Referral, Long-Term Care Services and Supports, Quality Management, and Finance and Payment reforms.
- In January 2009, the Global Consumer Choice 1115 Demonstration Waiver was approved by CMS. The overriding purpose of the 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 Waiver is built upon three fundamental goals: (1) to rebalance the State's long-term care system, (2) to integrate care management across all Medicaid populations, and (3) to complete the transition from a payer to a purchaser of care. It establishes a new State-Federal compact that provides the State with substantially greater flexibility than was available in previous guidelines. Rhode Island 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 Global Consumer Compact Choice Waiver demonstration. The compact waiver 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 Global 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 Global 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.
- The State has established a Long-Term Care Coordinating Council that meets regularly and has the Healthy RI Task Force that 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 stakeholders who have worked diligently to develop consensus recommendations for reform. The following describes our LTSS system and efforts to rebalance LTSS resources.

RI has 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

has developed and implemented a standardized long-term care assessment tool and created level of care criteria for long-term care services. In addition, RI has 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: (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 SFY 2013 the State has transitioned 30 individuals back into the community, and on average 100 people per year transition from a nursing home to the community.

To complement the rebalancing long term care initiatives, RI has implemented a multi payer Advanced Primary Care Practice demonstration, the Chronic Care Sustainability Initiative (CSI) and patient centered medical home initiatives. These efforts to strengthen primary care and the medical home concept provide a strong medical safety net for individuals as they transition into the community.

In April 2011, Rhode Island also received a Money Follows the Person (MFP) demonstration grant from the Centers for Medicare and Medicaid Services (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 Rhode Island is entitled *Rhode to Home (RTH)*. The RTH program introduced the use of Transition Coordinators who provide the intensive case management services required by elders and adults with physical disabilities during the demonstration period when the participant’s needs are greatest to ensure that participants have access to a comprehensive array of home and community based services (HCBS) and supports so that they successfully remain in the community. RTH will also provide Peer Mentoring services which is a necessary component of case management and supports for people with disabilities. Peer Mentor services will be designed to be provided during the transition period and thereafter, if necessary. Peer Mentors are individuals with disabilities who are successfully living in the community. We believe the initiatives underway will continue to position RI to achieve the goal of 50/50 balance of long-term care resources between institutional and home and community based care.

In June 2011, legislation was passed to change the payment methodology for Nursing Facilities. The proposal seeks to eliminate the cost basis principles of reimbursement and replace it with a base payment structure that reimburses Nursing Facilities appropriately based on the needs of the Medicaid beneficiary. Additional acuity payment adjustments would be factored into the payment methodology.

Today, the State Medicaid program offers a comprehensive array of institutional and community-based LTSS. These services and supports are found in Attachment A of the appended Model Contract. Currently, Health Plans are only required to provide up to thirty (30) days of nursing home care for RHP members and those members requiring more days are

disenrolled from the Health Plan. LTSS services are currently provided as an out-of-plan benefit for members enrolled in a Health Plan or in CCC.

The long-term care providers in the State include: 93 nursing homes (84 accept Medicaid recipients), approximately 56 home nursing care providers, 14 home care providers, 19 adult day care centers, and 51 assisted living facilities operating in different locations throughout the State. A list of the State's long-term care providers is contained in Appendix B².

Rhode Island licenses Home Nursing Care Providers and Home Care Providers. Home Nursing Care Providers provide 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 can provide assistance with daily living and personal care. Businesses that provide homemaker and companion assistance only, that is, they do not provide personal care or direct hands-on assistance with daily life care, do not require a license. 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."

2.5 Integrated Care Initiative

EOHHS and stakeholders recognized that there is an opportunity to improve the Medicaid program by enhancing the integration of all services required by ABD Medicaid recipients including primary care, acute care, specialty care, behavioral health care and long-term services and supports and to include those individuals who are Medicare and Medicaid eligible in those integration efforts. These populations have complex medical conditions, require a multi-disciplinary cadre of care and supports, and are costly to serve. It is not surprising therefore that the Integrated Care Initiative (ICI) focuses on these populations.

In 2010, the ACA recognized the needs of these population groups and promoted the coordination of services for adults with disabilities (ages 19 to 64) and for elders (age 65 and older). In July 2011, the RI General Assembly also recognized the importance of improving the systems serving these populations:

By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only beneficiaries and MME members.

As a result, the ICI was established.

² Source data for this information derived from the RI Dept. of Health Licensing database, January 2013

The vision of the State is to have an Integrated Health Care System for all Medicaid-only and MME members that will achieve improved health and well-being, better healthcare, at lower costs. EOHHS's mission is to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and MME recipients to maintain a high quality of life and live independently in the community.

A key requisite to meet the State's vision and mission for the ICI is to build on, improve, and integrate the current Care Management programs to better meet the needs of the target populations. The goals of ICI are the following:

- Enhance person-centered care
- Improve and maintain member's quality of life and 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 home admissions and length of stay

EOHHS's ICI is founded on a care philosophy to ensure that services are delivered in the most appropriate care setting for each member based on their medical, behavioral health and social service needs. This philosophy incorporates CMS' tenets of Managed LTSS:

- **Person-driven:** The system affords older people, people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.
- **Inclusive:** The system encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.
- **Effective and Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long term care needs, including greater use and awareness of private sources of funding.
- **Sustainable and Efficient:** The system achieves economy and efficiency by coordinating and managing a package of services that are appropriate for the beneficiary and paid for by the appropriate party.
- **Coordinated and Transparent:** The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.

- **Culturally Competent:** The system provides accessible information and services that take into account people's cultural and linguistic needs

In order to achieve the goal of full integration (primary care, acute care, specialty care, behavioral health care and long term services and supports), the State proposes to follow two primary pathways. This approach will allow for consumer choice and will ensure accountability, access and improved outcomes for MME members and those members requiring long-term care services and supports. Each of the models is not exclusive of the other and the State will pursue both major pathways in parallel. A summary of the primary pathways is below.

- **Pathway #1: Enhanced Primary Care Case Management (PCCM) Models**

The Enhanced PCCM Model, Connect Care Choice *Community Partners (CCCCP)*, builds on the Connect Care Choice (CCC) Program's demonstrated capacity and experience to serve individuals with complex medical conditions. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of "best practices" serve approximately 1,800 Medicaid-only beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCC is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

Under the *CCCCP* model, the strengths of CCC are combined with an enhanced capacity in care management and service integration across all service categories: primary care, acute care, specialty care, behavioral health and long-term care services and supports. This pathway preserves the core person-centered medical home aspect of the CCC and builds on the established chronic care model of best practices. For members needing LTSS, the LTSS care management and transition services would be performed by the state staff within the EOHHS Office of Community Programs (OCP). To address the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services and for high touch care coordination, a bundled service contract will be sought to build **Coordinating Care Entity (CCE)** which would oversee and manage the performance data, quality assurance and quality improvement activities and build a **Community Health Team (CHT)** that would coordinate the social supports and services for the Medicaid-only and MME members. The CCE would coordinate the high touch care management with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites and the EOHHS Office of Community Programs (OCP) Nurse Care Managers for the LTSS and CHT to provide linkages to social supports for a coordinated, seamless delivery system.

This CCE will be a community based entity with demonstrated expertise and the necessary tools to perform the coordination of the care management, care coordination, transition services, community based resource services, social supports, housing, transportation supports, and services integration functions in collaboration with the CCC

practices. For Medicaid-only members, the *CCCCP* will be a direct expansion of the existing CCC program to include an increased focus on long-term care services and linkages to social supports. For MME individuals, the CCE will take responsibility for coordinating care and service integration, through the CCC, OCP and CHT. This program will be operated under the direction of the Administrator of the Office of Long Term Services and Supports RI Medicaid Program.

RI Medicaid will seek to define the advanced model of primary care established by the *CCCCP* program and the contracted CCE/CHT as a “health home,” as defined by the Section 2703 under the Patient Protection Affordable Care Act. Under the “health home” program, the CCE, in concert with the CCC practice, OCP and CHT will be required to focus on prevention, reduce wasteful fragmentation, and avert the need for unnecessary and costly emergency department visits, hospitalizations and institutionalizations. We anticipate that an estimated three thousand five hundred (3,500) MME individuals as well as the existing 1,800 Medicaid only eligible ABD adults will choose this model.

The LTSS services that are currently funded and managed through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) will continue to be funded and managed through BHDDH. The Bidder shall be required to coordinate these services with the BHDDH social caseworker and the BHDDH support coordinator.

- **Pathway #2: Health Plan Model**

The State will contract with two or more Health Plans to provide the comprehensive array of primary care, acute care, specialty care, behavioral health, and long-term care services and supports to Medicaid-only adults who receive LTSS as well as to MME individuals who are eligible for full Medicaid benefits, under a capitation arrangement. The target populations for this procurement fall into four groups: (1) MMEs living in the community receiving no long-term care services or supports, (2) MMEs living in the community receiving long term care services and supports, (3) MMEs living in an institutional care setting, and (4) Medicaid-only adults who receive LTSS in a nursing home or in the community.

This model will be implemented in two phases.

Phase I of EOHHS’s approach to improving the Medicaid program is to enhance the integration of the full range of services (primary care, acute care, specialty care, behavioral health care and long-term services and supports) for all Medicaid eligible adults, importantly including persons who are dually eligible for Medicaid and Medicare. Additionally, as described below, certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness will not be included in Phase I.

Phase II includes the provision of all Medicaid covered benefits to the Medicaid only adults who receive LTSS and to all full benefit MMEs population, except for those individuals who are specifically excluded from this initiative. Phase II includes the

provision of all Medicaid benefits and Medicare benefits to the Medicaid only and to dually eligible Medicaid and Medicare individuals.

The Phase I initiative is scheduled to commence enrollment on September 1, 2013.

EOHHS intends that Phase II – slated to commence twelve months following the start of Phase I - will incorporate three additional critical components to the ICI. The successful Bidder must successfully meet the requirements of these components. These three components are:

Rhody Health Partners

Presently, just over 13,000 Medicaid-only (“non-duals”) beneficiaries are enrolled in the Rhody Health Partners program for all of their acute care services. LTSS waiver services are out-of-plan and continue to be Medicaid FFS. In Phase I, Rhody Health Partners program includes those individuals who are eligible for Medicaid only services, exclusive of LTSS. When an individual has been a resident in a long term care setting for more than thirty (30) consecutive days, that individual is currently disenrolled from Rhody Health Partners. Both of these events contribute to discontinuity of coverage for the enrollee. Individuals receiving LTSS and persons with greater than 30 days of consecutive residence in a long term care setting will be enrolled in Rhody Health Options in Phase I for the full scope of Medicaid services.

It is intended that at the start of Phase II, all of the Rhody Health Partners population will transition to be newly included in the enrollment for the Integrated Care Initiative. Participating Health Plans will be required to demonstrate their capability to meet all program requirements for this population. For additional background on this population the Procurement Library established in support of the Health Plan LOI includes the Data Book for rate determination for SFY 2013.

Services for Persons with Developmental Disabilities and Persons with Severe and Persistent Mental Illness (SPMI)

During Phase I all MME individuals in these groups will be enrolled in a Health Plan. However, during this period services that are currently funded and managed through BHDDH will continue to be funded and managed through BHDDH and will remain “out-of-plan” during Phase I.

During Phase II, EOHHS intends that those specialized services funded and managed by BHDDH for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements.

Each of these two population groups has a unique set of special needs and determining how best to serve these adults requires additional review and specification by BHDDH and EOHHS. 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 developmental disabilities and with SPMI will be well served within the ICI.

In consideration of transitioning those specialized services, in whole or in part, into a managed model in Phase II, EOHHS and BHDDH will establish program performance requirements and capabilities that will serve as the basis for managing these programs. This work will take place in the months following the release of the Health Plan LOI, to be completed by July 2013. The relationship between the Health Plans in Phase I and the design of specialized services for Phase II into an integrated system will be specified in the July 2013 requirements.

Medicare and Medicaid Financial Alignment

Pursuant to provisions of the ACA, CMS has established the Financial Alignment Initiative seeking to better align the financing of the Medicare and Medicaid programs and integrate primary, acute, behavioral health and long term services and supports for MMEs. Rhode Island is pursuing a three year CMS demonstration for a capitated model utilizing a three way contract between CMS, the state and qualified Health Plans covering all Medicare and Medicaid services.

To participate in this initiative Rhode Island, along with twenty-five (25) other states, submitted a proposal for participation in this demonstration. Rhode Island's proposal is currently undergoing CMS review. As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, CMS and participating States want to ensure that every selected Medicare/Medicaid plan (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 must pass a comprehensive joint CMS/State readiness review.

To participate in Phase II, Health Plans must meet all Medicare requirements established by CMS for the capitated financial alignment model, including Medicare Part D requirements. Every selected MMP must also pass a comprehensive joint CMS/State readiness review.

Phase I of Rhode Island's Integrated Care Initiative will occur prior to the target capitated Financial Alignment Demonstration start date, and is set forth as the initial step and foundation for participation in the Demonstration. MME individuals who are eligible for full Medicaid benefits will receive them in Phase I under the Rhody Health Options program. Phase II is intended to include the full integration of Medicare and Medicaid services through a three way contract. EOHHS is working with CMS to ensure that dually eligible beneficiaries in Rhode Island are able to benefit from this program. It is essential that successful vendors are able to provide evidence of their ability to qualify as a participating plan in this Demonstration.

The timing of this Phase II component may vary from those above and will be determined in concert with CMS.

Consumers may still elect to enroll in the PACE program administered by PORI who meet the eligibility requirements, pending the availability of the program's capacity to serve new members.

2.6 Enrollment Approach

The consumer will have a choice with regard to which model they will enroll in: the *CCCCP* Model, the Health Plan model, or the PACE model. However, the capacity to enroll new members is particularly limited with PACE, and somewhat limited with the *CCCCP* model. Member will also have a choice with the selection of the Health Plan that they will enroll in. This section highlights the number of individuals who are eligible for the ICI and the State's overall approach to enrollment.

The total eligible population that will participate in Phase I of the Integrated Care Initiative is approximately 28,578 individuals (900 current Rhody Health Partners members, 273 current CCC members, and 27,405 MME recipients). Once the program is fully operational, it is estimated that there will not be a net increase in monthly enrollments (i.e. new eligible members will be equal to the number of members who disenroll or become deceased in any given month, based on current eligibility criteria and population trends. It is further estimated that the total ICI population enrolled in the *CCCCP* model will be approximately 5,000 individuals and the remaining 23,578 will be enrolled in a Health Plan. PACE enrollment is estimated to remain the same.

When the ICI commences, the current recipients of Medicaid will be enrolled over a four month period for both the *CCCCP* and Health Plan models.

- **Month One:** Individuals who were previously enrolled in Rite Care, CCC or RHP and were dis-enrolled because Their status changed to MME (approximately 1,000 individuals)
- **Month Two:** MME and Medicaid-only individuals who reside in a nursing home and one-third of the MME population not receiving LTSS (approximately 10,000 individuals).
- **Month Three:** MME and Medicaid-only individuals who receive LTSS at home and one-third of the MME population not receiving LTSS (approximately 8,000 individuals).
- **Month Four:** The remaining one-third MME not receiving LTSS, and MME members with SPMI and MRDD clients (approximately 10,000 individuals).

Medicaid-only members currently enrolled in a Rhody Health Partners Health Plan and a participating CCC site will be sent a letter indicating that they may keep their current Health Plan (if that Health Plan is selected to participate in the Integrated Care Initiative) or CCC site, but will also be offered the option to change to the other Model. For members not enrolled in a Health Plan or assigned to a specific CCC site, they will be sent a letter indicating that they have been auto-assigned to one of the Health Plans. The auto-assignment to a Health Plan will be equal and random, but will take into account the following:

- If historical utilization data is available for primary care, and a member’s primary care provider (PCP) is participating in one of the participating Health Plans’ networks, auto-assignment will be made to that Health Plan.
- If an eligible member resides in a household with a RItE Care or Rhody Health Partners member(s), that member will be assigned to the same Health Plan as the RItE Care/RHP member, if that Health Plan is selected for the Integrated Care Initiative.
- If an eligible member was previously enrolled in RItE Care or Rhody Health Partners or CCC, and was disenrolled because of dual status or nursing home residence, auto-assignment will be to the last known CCC Site or Health Plan the member was enrolled in, if that Health Plan is participating in the ICI.

All members will be given the opportunity to change their auto-assigned Health Plan or to enroll in the CCC program if they choose to, within a six-week period.

To enroll new members, the State will make a “sweep” of all new eligible recipients, monthly. They will also be auto-assigned to a Health Plan based on the criteria cited above and a letter which will be sent to them two months prior to their enrollment date. These members will have a six-week period to change their auto-assignment. However, a member can choose to change between the Health Plan and the *CCCCP* model on a monthly basis (and vice versa). Members cannot however opt-out to fee-for-service (FFS) Medicaid.

A consolidated Member Services call center team will be created to answer incoming calls and to implement or make changes in the Health Plan and *CCCCP* assignments and to provide information about the PACE option.

The remainder of this LOI only pertains to the requirements related to the Coordinating Care Entity (CCE) in the Connect Care Choice *Communities Partners* Model.

CHAPTER THREE: PROGRAM AND TECHNICAL REQUIREMENTS

This chapter describes the major components of the Connect Care Choice *Community Partners* (*CCCCP*) program which is part of EOHH’s Integrated Care Initiative (ICI) and the requirements of the successful Bidder to serve as a Coordinating Care Entity (CCE). The six major functions of the CCE are woven into the discussion of the program to enhance a Bidder’s understanding and to put into context how the Bidder fits into the program design and operations. The specific requirements related to the CCE Bidder are noted throughout this chapter.

The six major functions of the successful Bidder to serve as the CCE include: (1) Enroll members in the *CCCCP* program and provide member & providers services; (2) Conduct an analytic risk assessment and an Initial Telephonic Health Screen to assess member needs for care management services; (3) Establish a Community Health Team and to serve as a Lead Care

Manager for members requiring non-medical social or “peer mentoring” services; (4) Comply with the principles of ICC and the requirements of the CCCC²P program (such as a person-centered system, development of a comprehensive Plan of Care to meet member needs, a multi-disciplinary provider team, an integrated and coordinated delivery of medical, behavioral health and LTSS); (5) Provide support to EOHHS for members who have transitioned from the Nursing Home Transition Program and the *Rhode to Home* demonstration grant to the CCCC²P program (by reporting critical incidences and developing Emergency Back-Up Plan and ensuring the capacity to meet member emergency needs); and (6) Provide EOHHS operational data reports on CCCC²P members and program activities.

Under the proposed agreement between the State and the successful Bidder, payment will be made on a capitated basis for conducting its responsibilities noted in this LOI and in the attached proposed Model Contract. The payment for Medicaid covered medically necessary medical, behavioral health or LTSS will be authorized and paid under the Medicaid fee-for-service system. Medicare services will continue to be paid by Medicare and in accordance with the Medicare requirements.

A Medicare member who has a PCP outside of the CCC practice site for Medicare funded services may select the CCCC²P for the Medicaid funded services. Bidders shall coordinate with Medicare funded service providers in order to meet the needs of the members.

The Bidder must have the capacity to provide high quality services in a cost-effective manner to eligible Medicaid populations throughout the State of Rhode Island as described in this LOI and in the attached Model Contract as well as embrace and comply with the following guiding principles and care philosophy of the Integrated Care Initiative.

The following are the guiding principles and care philosophy that Bidders are expected to embrace when serving Connect Care Choice *Community Partners* members under this procurement.

- Establish and maintain a person-centered care system
- Facilitate access to timely, appropriate, accessible and quality primary care, acute care, specialty care, behavioral health care, and long term supports and services
- Collaborate with the network of CCC practice sites designated by RI Medicaid for primary care
- Coordinate member access to the full continuum of Medicaid covered services through a multi-disciplinary network of Fee-for-Service providers
- Coordinate the Medicaid covered services with the Medicare service providers
- Promote an integrated and coordinated system of care that meets member needs

- Ensure that the primary care setting serve as an effective medical home
- Facilitate and track the member’s medical status, behavioral health, risk factors and human service conditions
- Track the integrated Plan of Care tailored to members medical, behavioral health, and long term services and supports
- Assure services are delivered in the most appropriate care setting for each member based on their medical, behavioral health, and social needs
- Increase the proportion of individuals successfully residing in a community setting
- 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 member needs
- Tailor “successful evidenced-based practices” from other environments to meet the needs of program members
- Maximize the use of information technology to improve access care and provision of care while reducing cost
- Empower members to self-direct their care, when appropriate
- Build on existing Medicaid long-term care re-balancing initiatives including the Money Follows the Person grant, *Rhode to Home*, to leverage existing resources and to improve health care outcomes

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

3.1 Model Contract Requirements

A key component of the LOI is the model contract. The model contract sets forth the terms of agreement with EOHHS for an award pursuant to this LOI.

Appendix C contains the model contract for the forthcoming procurement period. The Model Contract is organized as follows.

Article I: Definitions

Article II: Coordinating Care Entity Program Standards

1. General
2. Licensure, Accreditation, Certification
3. Coordinating Care Entity Staffing and Administration
4. Eligibility & Program Enrollment
5. Member Enrollment and Disenrollment
6. Coordination of Covered Services
7. Coordination of Non-Covered Services
8. Provider Networks
9. Service Accessibility Standards
10. Member Services
11. Provider Services
12. Care Management & Quality Assurance
13. Operational Data Reporting
14. Grievance & Appeals
15. Payment To Contractor
16. Coordinating Care Entity Fiscal Standards
17. Record Retention
18. Compliance

Article III: Contract Term & Conditions

1. General Provisions
2. Interpretations & Disputes
3. Contract Amendments
4. Payment
5. Guarantees, Warranties, & Certifications
6. Personnel
7. Performance Standards & Damages
8. Inspection of Work Performed
9. Confidentiality of Information
10. Termination of Contract
11. Other Contract Term & Conditions

- Addendum I: Fiscal Assurances
- Addendum II: Responsibilities under Title VI of the Civil Rights Act of 1964
- Addendum III: Responsibilities under Section 504 of the Rehabilitation Act of 1973
- Addendum IV: Drug Free Workplace Policy
- Addendum V: Drug Free Workplace Policy Provider Certificate of Compliance
- Addendum VI: Subcontractor Compliance
- Addendum VII: Certification Regarding Environmental Tobacco Smoke
- Addendum VIII: Instructions for Certification Primary Covered Transactions
- Addendum IX: Certification Primary Covered Transactions
- Addendum X: Liquidated Damages
- Addendum XI: Equal Employment Opportunity
- Addendum XII: Byrd Anti Lobbying Amendment
- Addendum XIII: Bid Proposal

Addendum XIV: Core Staff Positions
Addendum XV: Federal Subaward Reporting
Addendum XVI: Business Associate Agreement

Attachment A: Schedule of Medicaid Benefits
Attachment B: Schedule of Medicare Benefits
Attachment C: Schedule of Non-Covered Services
Attachment D: Nutrition Standards for Adults
Attachment E: Connect Care Choice Practices and Locations
Attachment F: Coordinating Care Entity's Capitation Rates
Attachment G: Coordinating Care Entity's Insurance Certifications
Attachment H: Quality and Reporting Requirements

Bidders are urged to read the model contract carefully and thoroughly. The model contract describes the binding requirements between the State and the Contractor. Bidders will be bound to the requirements and capitation rates contained in this Model Contract. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this Model Contract.

The following highlights the major elements and key requisites for being a successful Bidder and a compliant Contractor.

3.2 CCE Organization

The Bidder will meet all State general requirements as described in Chapter One and be properly registered and meet the State requirements to provide services covered by this LOI.

The Bidder will identify any license they hold and the licensure authority (e.g. the Rhode Island Department of Health or some other State agency) that licenses the Bidder.

The Bidder will identify any certification/or accreditation they hold by a State or National Body.

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

The Bidder will work with the State to implement the Health Homes Option in Section 2703 of the Patient Protection and Affordable Care Act (PPACA). The requirements for the Health Homes Option in Section 2703 of the Patient Protection and Affordable Care Act (PPACA) can be found in the Procurement Library.

The Bidder must be in good standing with the Medicare and Medicaid programs.

The Bidder must have extensive experience serving the Medicaid and Medicare beneficiaries. Experience in Rhode Island is preferred.

The Bidder must be financially solvent, have the capital, and have the financial resources and management capability to operate under this procurement's contract that reimburses the CCE through a capitation methodology.

The Bidder is required to have the staffing capacity with the appropriate expertise, the administrative procedures, organization structure and management information system to perform all the functions required under this contract (e.g. program and service development, member enrollment, member services, accounting and finance, quality assurance, care coordination, risk profiling, utilization tracking, data analytics and reporting).

The Bidders is required to have a primary office in the Providence area of the State of Rhode Island.

3.3 Implementation Schedule and Contract Period

The Bidder is expected to be ready to assume responsibility for the Phase I Contract between the Contractor and EOHHS on September 1, 2013. The Phase I Contract will continue in force until June 30, 2016, with three (3) one year option periods.

It is anticipated at this time that Phase II contract with EOHHS and the Contractor may include the provision of coordinating LTSS for intensive behavioral health and LTSS for individuals with developmental disabilities. A contract amendment will be executed to include coverage provision for these services.

3.4 Member Enrollment and Disenrollment

Marketing

The State assumes responsibility for marketing campaigns for Members pursuant to 42 CFR 438.104.

Enrollment

The Bidder has written policies, procedures, systems and practices that meet the requirements prescribed in Section 2.05 of the Model Contract. The State supplies the CCE on a monthly basis with a list of CCCP enrollees

The Bidder enrolls a member on the first day of the following month after receiving notification from the State. Members are mailed notification of CCE enrollment including effective date, how to access care and EOHHS developed CCC Fact Sheet and LTSS Brochures within ten (10) calendar days after receiving notification from the State of their enrollment. The Bidder agrees to report any changes in the status of individual member within five (5) days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, death and sources of third-party liability.

The Bidder provides a toll-free member service call line for additional program information for new members 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. The Bidder must have capacity to meet the linguistic needs of the members. Instructional materials relating to members 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 members are informed that information is available in alternative formats and how to access those formats.

The Bidder has call scripts to also solicit whether members 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 member service call identifies any new members who have existing health care needs immediate steps will be taken (e.g. referral to the OCP Care Manager or to the CCC Nurse Care Manager to ensure the member's needs are met). Any scripts developed or used by the CCE are subject to review by EOHHS. The Bidder tracks and monitors member service activities.

Materials

The Bidder mails an EOHHS developed CCC Fact Sheets and LTSS brochures all members within ten (10) days of being notified of their enrollment. At the State's direction, the Bidder sends revised EOHHS materials. The Bidder develops a Fact Sheet on the CCCCP program, role of the CCE, Connect Care Choice, OCP, DEA and Community Health Team (CHT), housing

information, Falls Prevention programs, and when to use the PCP, Urgent Care, Emergency Department. Such materials meet the requirements outlined above.

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

Dis-Enrollment

The State has sole authority for disenrolling members from CCE, subject to the conditions described in the Model Contract. The Bidder may not disenroll a member. The Bidder refers disenrollment requests to EOHHS for determination.

3.5 Services and Accessibility Standards

The CCCC member is eligible for the full range of primary, acute care, specialty care and LTSS. These services represent a continuum of care to meet the diverse and often complex needs of CCCC members. The Medicaid covered services are listed below.

TRADITIONAL BENEFITS	HOME AND COMMUNITY BASED SERVICES
Inpatient Hospital Care	Assisted Living
Outpatient Hospital Care	Homemaker
Physician Services	Environmental Modifications
Family Planning Services	Special Medical Equipment (Minor Assistive Devices)
Prescription Drugs	Home Delivered Meals
Non-Prescription Drugs	Personal Emergency Reponses System (PERS)
Laboratory Services	Community Transition Services
Radiology Services	Residential Support
Diagnostic Services	Day Support
Mental Health & Substance Abuse-Outpatient	Supported Employment
Mental Health & Substance Abuse-Inpatient	RIt@ Home
Home Health Services	Private Duty Nursing
Home Care Services	Support for Consumer Direction
Emergency Room Services & Transport	Participant Directed Goods & Services
Nursing Home Care & Skilled Nursing Facilities	Case Management
Other Practitioner Services (e.g. PA, CSW, Mid-wife)	Senior Companion
Podiatry	Personal Care Assistance Services
Optometry	Respite
Emergency Oral health	
Hospice	
Durable Medical Equipment	PREVENTIVE SERVICES
Nutrition Services	Homemaker
Group Education	Minor environmental Modifications
Interpreter Services	Physical Therapy
Transplants	Respite
Adult Day Care Services	

The services and programs are fully described in Attachment A of the Model Contract that will be funded through the Medicaid fee-for-service (FFS) program. Appendix D of the LOI describes the publicly funded LTSS.

The case management provided by the CCE for social services are included in the capitation rates contained in the Model contract and therefore the CCE is not eligible for any direct Medicaid FFS reimbursement. Also, certain services for individuals with Developmental Disabilities and individuals with SPMI will continue to be funded and managed by the BHDDH in Phase I

The Primary Care Provider (PCP) is required to ensure coverage, to members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are unable to provide such coverage, Bidders must ensure that Member's are informed on how to access services for instances where the PCP is not available.

The State and providers must meet access standards in the provision of timely and accessible care to emergency room, urgent care visits, behavioral health care, specialty care and LTSS.

3.6 Provider Network

A robust multi-disciplinary provider network for is available to CCCC^P members (1) that provide the full range of covered services inclusive of primary care, acute care, specialty care, behavioral health care and LTSS, (2) that has providers in sufficient number, mix and geographic area, and (3) makes available all services in a timely manner.

The CCE will coordinate with the medical, behavioral health and LTSS providers involved in a participant's case when the providing social services case management including but not limited to:

- **Connect Care Choice Participating Primary Care Practice Sites.**
Each CCE member participant is assigned a Connect Care Choice (CCC) primary care provider to serve as the member's participant's medical home. The Primary Care providers may be a primary care physician, an internist, a gerontologist or other providers specified in the Model Contract. All of the CCC primary care provider sites are designate as NCQA Patient Centered Medical Homes (PCMHs). The CCC practice sites provide and coordinate the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. Within each of the CCC practice sites, the State has integrated a nurse care manager to provide the clinical care management services. The successful Bidder will collaborate with the designated nurse care manager in the CCC practice sites as part of the CCCC^P program. All of the 17 CCC practice sites will be in the CCCC^P program. The enrollment approach for the MME individuals will be targeted at eight of the CCC practice sites. A listing of CCC practice sites and the targeted sites for the MME enrollment is provided in Appendix B.

- **State Agencies Involved in LTSS**

Several State departments and offices, operating under the Executive Office of Health and Human Services, are involved in the financing, administration, and management of the publicly funded LTC system and therefore will be intimately involved in the Enhanced PCCM Program model. These include but are not limited to the following: The LTC Field Offices are responsible for determining whether or not beneficiaries meet the financial eligibility requirements for the LTC Medicaid Program; the Office of Medical Review (OMR) determines the clinical eligibility of beneficiaries applying for Medicaid-funded long-term care; the Office of Community Programs (OCP) responsible for managing the health and long-term care needs of medically complex individuals with chronic conditions through the Nursing Home Transition Programs; the *Road to Home* demonstration grant to transition persons residing in institutional setting for more than 90 days to eligible community-based settings; the self-directed Personal Choice Program that provides individuals with the opportunity to hire and manage their own Personal Care Assistants and the option to purchase goods and services not otherwise covered under Medicaid; the RItE @ Home program to reside in a Shared Living residence available for adults who cannot live alone and require a considerable amount of help with the activities of daily living, such as eating, dressing, and personal hygiene to reside in an approved shared living residence; and The Office of Durable Medical Equipment and Home Modifications (ODMEHM) for durable medical equipment and supplies.

The Division of Elderly Affairs (DEA) provides a wide range and scope of programs and services for older Rhode Island residents with funding through the Older Americans Act. The Department administers over 100 community-based grants covering regional nutrition projects; senior centers; older volunteer programs; regional case management agencies; adult day program services, assisted living program, co-pay program and specialized programs for hearing and visually impaired elders. DEA also administers The Aging and Disability Resource Center (The POINT) provides information, referrals, and help getting started with programs and services for seniors, adults with disabilities, and their caregivers. The POINT is often the first place beneficiaries and their families call for information about the publicly funded long-term care system.

Appendix E describes the State agencies and programs that the CCE will be required to coordinate with.

3.7 Person Centered System

Person Centered Care Management

The Bidder must operate within the context of a person-centered system that governs the care provided to CCCC members. The focus of a person-centered system is on the individual, their strengths, and their network of family and community support 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.

A person-centered system respects and responds to individual needs, goals and values. Within a

person-centered system, individuals and providers work in full partnership to guarantee that each person's values, experiences, and knowledge drive the creation of an individual plan as well as the delivery of services. A person-centered system is built on the principle that members' Medicaid participants 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.

A person-centered system is strength based. Interventions are crafted based on the unique set of strengths, resources, and motivations that each member brings. The member, or his/her designee, is meaningfully involved in all phases of the care management process including in the: Comprehensive Needs Assessment of needs, development of an integrated Plan of Care, 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 the member has the primary decision-making role in identifying his or her need, preferences and strengths, and a shared decision making role in determining the services and support that are most effective and helpful to them. Person-centered systems require the leveraging of existing community resources to support member needs and the involvement of the member's informal support system. Person-centered system often requires linkages with community resources to address the non-medical needs of members. Most importantly, person-centered system requires direct "High-Touch" face-to-face contact throughout the care management process between care manager/providers with the member. The Bidder must ensure that these values and requisites prevail in the program for CCCC members are embraced. The person-centered system facilitates a partnership among the member, his/her family, providers, and treatment team coordinators.

The following are illustrative key requisites of a person-centered system:

- Member participates 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 should not face any penalty or reduction in benefits for exercising freedom of choice.
- Member has control over who is included in the planning process.
- Member has choices about the extent of involvement of their personal care provider(s) in their individual care team and appeal processes (ranging from no involvement to acting on individual's behalf for all care decisions).
- Member has the right to choose to designate someone (e.g. a trusted family member, friend or care giver) to serve as their representative for a range of purposes or time periods. 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 person.
- Member is a part of the Interdisciplinary Care Management Team, as appropriate.

- Care planning meetings are held at a time and place that is convenient and accessible to the member.
- CCE provide information that allows an individual member to understand and make informed decisions about service options, including providing information about *Olmstead* rights to all individuals who use LTSS.
- Mechanisms are in place to minimize conflict of interests in the facilitation and development of the plan.

Self-Directed Programs

For members requiring LTSS, 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 live at home. Many members participating in a self-directing program share authority with or delegate authority to family members or others close to them. Designation of a representative enables minor children and adults with cognitive impairments to participate in self-directed programs.

Self-direction represents a major paradigm shift in the delivery of publicly funded home and community-based services (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. Rhode Island 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 Rhode Island, 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.ohhs.ri.gov>.

Rewarding Work (www.rewardingwork.org) is a website that provides an online registry of personal care assistants/individual support providers to people with disabilities and/or their families. Rhode Island 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. Rhode Island 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

In addition, entities that provide care management and care coordination to participants in the above programs have access to the Registry as well in order to assist participants in locating and hiring support staff. Rhode Island has participated in Rewarding Work since 2007 and there are currently 750 Medicaid recipients and/or their families who have memberships subsidized by this agreement and they have access to a pool of approximately 2800 workers from which to choose from.

The Bidder is also required to understand the tenants of a self-directed program. The self-directed program enables the member to take a more active role in the identification of resources and in the direct management of care and support services provision, where appropriate. The Bidder will work with EOHHS in adopting self-directed programs and in identifying the appropriate population groups and members to participate in a self-directed program.

The State will continue to manage the existing self-directed program, Personal Choice program. The Bidder is required to coordinate with PARI and Tri-Town for the program operations that support self-directed members for the data reporting and monitoring of the *CCCCP*. (These sub-contractors conduct on-line assessments, background checks on care givers as well as serve as a fiscal intermediaries and advisors to members).

3.8 Risk Profiling

The Bidder is required to have policies, procedures, practices and systems that identify *CCCCP* members who require, who are at “risk” of requiring, and who may benefit from CCC or state care management resources. Bidders must establish priorities regarding who receives care management as well as the amount and scope of care management members receive. The identification of members requiring care management occurs initially upon enrollment and continues throughout the care delivery process. The current CCE population consists of individuals with varying medical and behavioral health needs, who are in different care settings, and are in different-stages of their life. Consequently, members require different levels and types of care management. Conceptually, there may be members with High Level (Level I) and Low Level (Level II) needs depending on the complexity of their conditions and the availability of their existing informal support network. It is envisioned that High Level (Level I) would be referred to the CCC Nurse Care Manager for complex medical issues and at risk for hospitalization or referred to the OCP Nurse Care Manager or DEA Home and Community Care

managers for members at risk for institutionalization or have been determined meeting an institutional Level Of Care. In essence, Bidder must use a Risk Profiling Modeling capability that identifies members with immediate care management needs and identifies those who are “at risk” of requiring care management and may benefit from care management. This type of assessment enhances positive healthcare outcomes as a result of interventions provided to members. A thorough analysis of claims data, assessment data or data from other systems over a two-year period can be used in Risk Profile Modeling. A risk score is used to establish the level and type of action or care management that is required. For example, some members may only require a Telephonic Screen, others may require a Comprehensive Assessment, others may require the development of a Plan of Care, still others may require a Peer or Para-Professional Care Manager, while other members may require a Medical or Social Work clinical professional Care Manager. A data “sweep” and subsequent analysis of the data to identify new members requiring care management assessment shall be conducted every six (6) months.

The Bidder is required to establish the CCCCCP members risk score and assignment to the type of action or care management within five (5) business days of the effective enrollment date.

The ability of intervene at any given point of time is most critical to the next treatment phase or to the outcomes of intervention on members. Member needs change throughout the care delivery process and thus their care management needs change. The Bidder must have an integrated system that analyzes data and tracks a member’s condition and documents events (e.g. emergency room encounters, hospital admissions, nursing home admissions) that suggest a member requires care management. The system must provide the Care Managers with vital information in a timely fashion so that the appropriate interventions (e.g. care coordination, care management or additional services and supports, Plan of Care changes) may be provided to improve a member’s health care status and to avoid unnecessary use of limited resources.

3.9 Care Management

The Bidder must operate within the context of the CCCCCP care management system. The following describes the care management system for CCCCCP.

The mission of the Integrated Care Program is to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and Medicaid/Medicare eligible (MME) members to maintain a high quality of life and live independently in the community. Care management is a critical component of this strategy. EOHHS will build upon, improve and integrate with current Care Management programs to better meet the needs of the target population. Care should be less fragmented and more person-centered; care managers should strive to better communicate across settings and providers; and members should have greater involvement in their care management.

The goals of care management are to:

- **Improve member health and quality of life** as indicated by: (1) improved quality of care, health outcomes and quality of life for members, (2) ensured involvement of members

and their families in the care management process, (3) promoted effective and ongoing health education and disease prevention activities, and (4) provided and coordinated support for family caregivers

- **Decrease Care Fragmentation** as indicated by: (1) provided maximum physical and functional integration of care management through the primary care site, when possible, (2) facilitated access to timely, appropriate, accessible, and person-oriented physical and behavioral health care, long-term services and supports, and other community based resources, (3) increased communication and coordination of care across all members of the care team, and (4) identification of duplicative care management activities and the designation of a principle care manager.
- **Optimize Resource Utilization** by reducing avoidable emergency room visits, hospitalizations, and nursing home admission and lengths of stay.

Optimal care management requires a combination of three basic types of activities: (1) a set of “high-touch,” person-centered, care management activities requiring direct interaction with the member and the care team, (2) data collection, analysis, interpretation, and communication of data to the care team, and (3) monitoring and quality assurance of care management activities.

EOHHS believes that for certain individuals, person-centered care management activities are optimally delivered when functionally and, where possible, physically integrated into a multi-disciplinary, primary care-based practice team with the capacity to support this function. The Integrated Care program will develop over time to improve access to on-site, integrated care management services to the greatest extent possible.

The Bidder is required to coordinate care management for social service required by CCCC*P* members. The Bidder is required to document those members who decline care management and the reasons for denial. The Bidder is also required to coordinate care management social services for CCCC*P* members who may benefit from care management such as members with complex medical conditions or members that exhibit “risk” behaviors that may lead to institutional care or high cost services. The Bidder must establish early warning system and procedure that foster the early identification of “at-risk” member and has the capability to identify member’s emerging needs. The Bidder is required to review the information gathered during the assessment process outlined below, document responses and determine who may benefit from care management and refer as appropriate. The Bidder is also required to have effective systems, policies, procedures and practices in place to identify members in need of care management services.

Care management consists of the following major components: (1) Initial Telephonic Screen (2) Comprehensive Needs Assessment, (3) Designation of a Care Manager, (4) Development of a Plan of Care, (5) Creation of a Multi-Disciplinary Care Team, (6) Implementation, Coordination and Monitoring of Plans of Care, (7) Transition Care Planning, and (8) Analysis of Care Management Effectiveness, Appropriateness and Patient Outcomes. These components are discussed below.

Initial Telephonic Screen

The Bidder conducts a Initial Telephonic Initial Health Screen on all new members not currently receiving long-term care services and supports (LTSS) within sixty (60) days during the initial program enrollment, within forty-five (45) days for on-going program enrollment and every one hundred and eighty (180) thereafter, unless member conditions or needs dictate otherwise.

The Bidder uses a structured and standardized screening instrument to serve as a guide to conduct and to document the results of the Telephonic Initial Health Screen. The Telephonic Initial Health Screen explores the member's condition and potential need for care management services. The result of this assessment is to identify those members who require a Comprehensive Needs Assessment. The Bidder has policies and procedures governing the Telephonic Initial Health Screen Assessment including the instrument and the criteria to be used to select members who will receive a Comprehensive Functional Needs Assessment that is part of the Bidder's Care Management Plan, approved by EOHHS. EOHHS reserves the right to designate the screening tool.

Comprehensive Needs Assessment

An in-person Health Risk Assessment (HRA) must include at a minimum the following assessment tools: PHQ, SF-36 and the Katz functional assessment. Upon completion, the HRA must be submitted to the CCE within two (2) business days. The Comprehensive Needs Assessment is conducted for the following three populations:

- **Members Risk Profiled as Level I.** Upon referral by the CCE, the HRA is conducted by the CCC Nurse Care Manager, the OCP Nurse Care manager or DEA Care Manager. The initial HRA shall be completed within thirty (30) days during the initial program enrollment and fourteen (14) days for on-going program enrollment. The in-person reassessment is conducted annually or sooner if required based on the member's conditions or needs.
- **Members Risk Profiled as Level II.** The HRA is conducted by a licensed Social Worker or paraprofessional. The paraprofessional may conduct the assessment under the supervision and oversight of a licensed clinician. The initial HRA is conducted within one hundred and eighty (180) days of the initial program enrollment and within ninety (90) days of on-going enrollment. An in-person home visit is conducted annually for Level II members. Level II Comprehensive Needs Assessment may be conducted by either State Staff from the OCP, DEA or the CCE staff the depending on the anticipated severity of needs.
- **Members Living in the Community who are not using Long Term Services and Supports (LTSS) but were Determined to be "At-Risk" and would Benefit From Care Management During the Initial Screen.** The HRA is conducted by a licensed Social Worker or paraprofessional. The paraprofessional may conduct the assessment under the supervision and oversight of a licensed clinician. The HRA is conducted within thirty (30) days during the initial enrollment and fourteen (14) days for on-going enrollment for members being selected to receive care management.

The in-person re-assessment is conducted every six (6) months or sooner if required based on the member's condition or needs. For non-LTSS members, a licensed Social Worker or paraprofessional (non-licensed may conduct the HRA). The paraprofessional may conduct the assessment under the supervision and oversight of a licensed clinician. For members at risk of institutionalization, a limited package of preventive services for 30 days or less of community based CNA/ personal care/homemaker services may be coordinated.

A member is entitled to a consultation and an Initial Telephonic Screen within fifteen (15) days of a member's or caregiver's request.

For post-hospitalization, a home re-assessment must occur within five (5) days and adjustments to the Plan of Care will be made, as necessary.

The Comprehensive Needs Assessment is conducted in-person face-to-face at the member's residence. A licensed clinician (e.g. Nurse, Clinical Social Worker) shall perform the assessment for Level I members. Paraprofessionals with oversight from a licensed clinician may perform a Level II Comprehensive Needs Assessment in-person face-to-face.

The Comprehensive Needs Assessment is strength based and person center assessment that, at minimum, covers the following to determine member existing condition, level of needs and individual preferences:

- Medical history
- Functional status
- Mental health screen
- Cognitive functioning and dementia
- Alcohol, tobacco, and other drug use
- Nutritional status and food availability
- Medication management
- Social service needs (heating, food insecurity, etc.)
- Risk factors identification
- Identification of avoidable hospitalization or other high cost institutional care
- Housing
- Home Modifications (i.e. ramps, vertical platform lifts)
- Informal support system
- Other service needs (e.g. legal)
- Need for specialized care management (e.g. for people with history of homelessness, people with intellectual or developmental disabilities, history of substance abuse, etc.)
- Home safety evaluation
- Family structure and social supports
- Well-being (self-report)
- How to report abuse and neglect
- Willingness or interest in vocational rehabilitation or future employment
- Self-identified areas of unmet needs and wants, such as transportation arrangements

- Information about advocacy agencies to support the member such as the State Ombudsman
- Information regarding statewide health information exchange: **CurrentCare**

During the initial LTC eligibility process, State staff authorizes LTSS for a transitional period (may be a thirty (30) day period) and provides the Contractor with all relevant clinical and authorization materials to use in the Comprehensive Needs Assessment conducted in the member's residence. State staff shall continue to authorize all LTSS services.

In conforming to the precepts of a person-centered system, the member, his/her care giver, and family takes an active role in identifying member conditions, strengths/weaknesses, and unmet needs.

Community Health Team

The Bidder is required establish a Community Health Team (CHT). The Community Health Team may serve as Lead Care Manager for members, who have social needs, may require linkages with community resources, or require a "peer mentoring" relationship. (Member's with complex medical and human service needs will be assigned to State care managers from the State's various care management programs cited in this LOI). The Community Health Team includes a community-based interdisciplinary, inter-professional team to support the needs of the member to achieve the mutually agreed upon Plan of Care. The composition of the CHT may include nurses, social workers, and peer navigators.

The Bidder is required to have the capacity to staff the CHT. The Bidder and have the necessary policies, procedures and systems so that the CHT meets its responsibilities, as describe in this LOI.

The specific functions of the CHT as a Lead Care Manager are discussed below.

Designated Lead Care Manager

Every member receiving care management services has a designated lead Care Manager. The background, training and experience of the lead Care Manager shall be determined by the member's principal needs. The Lead Care Manager may be a registered and licensed nurse for those members with complex and chronic medical conditions or at risk of hospitalization and currently serving as a Connect Care Choice Nurse Care Manager. The Lead Care Manager may be a registered and licensed OCP nurse for those members at risk of institutionalization, DEA Care Manager and or a State Social Worker and for members receiving LTSS or for members with complex human services needs. The Bidder's or CCE staff may serve as the Lead Care Manager for those members who have social needs, may require linkages with community resources, or require a "peer mentoring" relationship. The Bidder will establish and the State will approve minimum qualifications and experience for the Bidder's Care Managers and CHT staff as outlined in the Procurement Library. The Bidder has policies and procedure for assigning Care Managers to ensure an equitable distribution of workload. The Bidder also has established case load for the Bidder's Care Managers, approved by EOHHS.

For Level I members, the Lead Care Manager's responsibilities may typically include:

- Person-centered development of a Plan of Care
- Coordination of care with specialists
- Follow-up with providers to obtain treatment results
- Medication Reconciliation/Medication Management
- Coordination of transitions between acute and institutional settings of care
- Provide health education including the proper use of medical resources including the emergency room
- Provide or link to self-management and disease management education
- Explain desired treatment results and outcomes
- Coordinate the delivery of medical, behavioral health care, and long-term care
- Track and monitor Plan of Care progress and achievement of treatment goals and objectives
- Review periodically the Plan of Care and making appropriate revisions in collaboration with the member and the member's provider(s) and the inter-disciplinary care team
- Assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies
- Coordinate service delivery among all the providers associated in the care, and
- Advance Care Planning/Will
- Offer enrollment in the Statewide Health information exchange, **CurrentCare**

The Lead Care Managers for Level I members will not be from the Bidder (CCE).

The Lead Care Managers for Level II members may be from State or Bidder's (CCE) staff depending on member needs. Members with complex medical and human services needs may likely be assigned a lead Care Manager from State staff. A member of the Bidder's Community Health Team will likely serve as the Lead Care Manager for members who have non-medical social services needs, require linkages to and coordination with community resources, or require a "peer mentoring" relationship. The responsibilities of the Lead Care Manager for Level II members include, but are not limited to:

- Participate in development of a Plan of Care
- Conduct in-person home visits
- Outreach to members
- Assist with making appointments for health care services
- Cancel scheduled appointments if necessary
- Assist with transportation needs
- Follow up with members and providers to assure that appointments are kept
- Reschedule missed appointments
- Link members to alternatives to high-cost or intensive medical resources including the emergency room, when appropriate
- Assist members to access both formal and informal community-based support services such as child care, housing, employment, transportation and social services
- Assist members to deal with non-medical emergencies and crises

- Assist members in meeting Plan of Care goals, objectives and activities
- Provide emotional support to members, when needed
- Coordinate the provision of care with providers and other care managers
- Enroll members in RI Special Needs Emergency Registry
- Serve as a role model in guiding the member to practice responsible health behavior
- Assist with linkages to caregiver support resources

The Bidders must employ only State licensed clinical staff for persons enrolled in the *CCCCP* program. Para-professionals or non-licensed staff may serve as Lead Care Managers for members requiring non-medical social services, require assistance coordinating with community linkages, or require a “peer mentoring” relationship.

The State maintains the right to approve the type of Care Managers, their background and experience, the populations they serve, their roles and responsibilities, and their caseloads.

Plan of Care

A Plan of Care is developed for all *CCCCP* members who receive care management. The Plan of Care reflects the needs of the member as identified in the Comprehensive Health Risk Assessment. The Plan of Care is based on a structured predefined format prescribed by the State that will also be flexible to document individual member needs. The development of the Plan of Care is a collaborative process with the member, his/her designee, Care Manager, Primary Care Provider and other medical or human service providers, depending on the members needs. The Plan of Care is comprehensive and documents the needs and interventions based on a member’s medical, behavioral health, long-term care, human services and other critical needs or plan (e.g. legal or housing) related to the member. The Plan of Care reflects that members receive needed care and services through a seamless, person-centered and integrated system. The Plan of Care balances formal and informal community and family resources. The Plan of Care is personalized and built on member strengths and preferences. The Plan of Care establishes the framework to integrate and coordinate the entire range of care required by the member.

The Plan of Care and its related processes will advance the principles and tenets of the person-centered system. Examples of these principles and tenets include, but are not limited, to the following:

- The person centered plan integrates all elements of needed medical, clinical, and community living supports. An integrated care team with both clinical and LTSS expertise have responsibility for developing and implementing the plan.
- The Plan of Care is prepared in person-first singular language and is comprehensible to the consumer and/or representative.
- In order to be strength based, the positive attributes of the member is documented at the beginning of the plan.

- The Plan of Care identifies risks and the measures taken to reduce risks without restricting the individual's autonomy to undertake risks to achieve goals.
- Goals are documented in the member's or their representative's own words and the amount, duration, and scope of services and supports is understood by the member.
- Specific person(s) and/or any provider agency responsible for delivering services and supports are identified.
- The Plan of Care includes a discussion of acute care preferences and anticipates care transitions needed for a return to the community from any temporary emergency room, hospitalization, or nursing home admission, as well as transitions requested by any individual who desires and is capable of a less restrictive community placement.
- Other non-paid supports and items needed to achieve the goal are documented. The Plan includes the signatures of all people with responsibility for its implementation, including the individual and/or representative, and a timeline for plan review.
- The Plan of Care identifies the person and/or entity responsible for monitoring the Plan and everyone involved (including the beneficiary) must receive a copy of the Plan.
- The Plan of Care includes strategies for resolving conflict or disagreement within the process, and includes clear conflict-of-interest guidelines for all planning participants, as well as a method for the beneficiary to request revision of a plan, or referral to Medicare or Medicaid to appeal the denial, termination, or reduction of a service.

The follow are topics that are covered in the Plan of Care covers, at a minimum:

- Member's physical and behavioral health status
- Primary and secondary diagnosis
- Functional needs and status
- Chronic conditions
- Short and long term goals, objectives, and expected outcomes
- Barriers to goals, objectives, and expected outcomes
- Medical interventions needed
- Disease and self-management interventions needed
- Medication Management
- Prevention and wellness interventions needed
- Interventions to address special needs (e.g. pain management, cognitive impairment, physical/vocational/speech therapy)
- Behavioral Health interventions needed

- Developmental disability services required
- Long-term interventions (institutional and HCBS)
- Informal support system interventions
- Emergency Back-Up Plan for members receiving LTSS
- Self-directed services and supports
- Social service interventions
- Other required interventions (e.g. housing, legal, recreational)
- Advanced Care Planning/Living Will
- Risk Mitigation Plan to address members' risk-factors for LTSS members

The Plan of Care identifies the amount, scope, intensity and duration for services and interventions. The Plan of Care will also indicate responsibilities for the coordination of care and the periodicity for reviewing Plans of Care.

The Plan of Care for members is discussed at the multi-disciplinary care team meeting, as appropriate

All Plans of Care are submitted to the State for authorization. Once authorized the Bidder notifies the designated Lead Care Manager and distributes the Care of Plan to the multi-Disciplinary Care Team members.

The State coordinates the benefits, care management, and requirements of member who are participants of the Federal Money Follows the Person demonstration grant, *Rhode to Home*, and transitioned to the CCCCPC upon the conclusion of the member's enrollment in the Money Follows the Person Demonstration (365 days). The Bidder incorporates the data pertaining to the *Rhode to Home* participants into the Plan of Care upon conclusion of enrollment in the *Rhode to Home* program.

The State coordinates the benefits, care management and requirements for members who are participants of the Nursing Home Transition program and transitioned to the CCCP. The Bidder incorporates the data pertaining to the Nursing Home Transition participants into the Plan of Care upon conclusion of enrollment in the Nursing Home Transition program.

The State is responsible for the development of a standardized, flexible and informative Plan of Care format. Level II Plans of Care that are developed by the Bidder must be submitted to the State for approval, within three (3) business days of the Plan of Care completion. The Bidder will have policies and procedures to develop and monitor Level II Plans of Care that they develop. Bidders will have procedures in place to monitor and follow up implementation of individual's person-centered plans. This process includes mechanisms to ensure that paid and unpaid services and supports are delivered, and that integrated care teams monitor progress toward achieving individuals' goals, and review the care plan according to the established timeline. The Bidder must provide a feedback mechanism for the individual to report on progress, issues and problems. The Bidders policies, procedures and practices related to Plans of Care must be approved by the State.

The Bidder will be required to demonstrate the IT capacity to support the care management

activities. The bidder will be required to utilize the State's care management tool, Atlantes, once the system is operational. It is anticipated that the Atlantes tool will be operational after the effective date of the model contract.

Multi-Disciplinary Care Team

A multi-disciplinary care team is assembled to meet the member needs as identified in the Comprehensive Health Risk Assessment and the required intervention services and supports noted in the Plan of Care. The Care Team consists of, at minimum:

- Member
- Family member and care givers, at the discretion of the member
- Care Manager
- CHT member, if appropriate
- Primary Care Provider
- Behavioral Health Specialist, if appropriate
- Therapists, if appropriate,
- Long-term care provider, if appropriate
- Pharmacist, if appropriate
- Other key medical specialists or human service providers, if appropriate

The Bidder must establish policies, procedures and practices to ensure the assembly and proper functioning of a Multi-Disciplinary Care Team to meet member needs, including the frequency of Care Team meeting. The Bidder also ensures that Care Team meeting are conducted at times and locations that considers the members circumstances. The State reserves the right to approval the policies, procedures and practices related to the Care Team the establishment and functioning of Care Teams.

New members may have been receiving primary care services through a Primary Care Mental Health (PCMH) site. The Care Managers of those sites must be an integral part of the Care Management team for those members.

Members may be receiving co-located behavioral health services through the CCC practice site. The behavioral health clinician at the site is an integral member of the care management team.

A representative of the Multi-Disciplinary Care Team contacts a member every sixty (60) days.

Conflict Free Case Management

EOHHS intends to submit an application to CMS for the Balancing Incentive Program (BIP). BIP requires States to develop, as part of their No Wrong Door/Single Entry Point (NWD/SEP) systems, conflict free case management services. Conflict-free case management has the following characteristics:

- ***There is separation of case management from direct services provision:*** Structurally or operationally, case managers should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide no other direct services. This prevents financial pressure for case managers to make referrals to their own organization or the “trading” of referrals.
- ***There is separation of service eligibility determination from direct services provision:*** Eligibility for services is established separately from the provision of services, so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual.
- ***Case managers do not establish funding levels for the individual:*** The case manager’s responsibility is to develop a plan of supports and services based on the individual’s assessed needs. The case manager cannot make decisions as to the amount of resources (individual budget, resource allocation, or amount of services).
- ***Individuals performing evaluations, assessments, and plans of care cannot be*** related by blood or marriage to the individual or any of the individual’s paid caregivers, financially responsible for the individual, or empowered to make financial or health-related decisions on behalf of the individual.

The State maintains responsibility for eligibility and service authorizations for CCCCCP members. The Bidder must demonstrate that their Care Management programs contain the necessary elements of conflict free case management.

Implementation, Coordination and Monitoring of the Plan of Care

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

- Refer members to service
- Track and follow-up on care
- Serve as a “communication hub” in the coordination of care between primary care, specialty care, behavioral care, institutional care, LTSS and end of life care
- Communicate and refer to community-based resources
- Support transitions from hospital to community or nursing facility to community
- Provide member education and self-management support
- Collaborate with providers
- Utilize behavior change techniques and motivational interviewing practices
- Coordinate of medication management with a pharmacist,

- Coordinate the provision of community-based services and supports
- Refer as appropriate to end-of-life services and supports
- Monitor changes in member's conditions and needs
- Monitor the impact of services and care, and the need to continued or additional services

As previously indicated, the Bidder determines the roles, responsibilities and caseloads for the Bidder's Care Managers. The State reserves the right to approval the policies and procedures related to the designation of Care Managers.

The Lead Care Manager must coordinate with providers for the provision of all non covered services. The bidder is expected to coordinate behavioral health services with providers who are funded by BHDDH for the Severely and Persistently Mentally Ill (SPMI) members and persons with developmental disabilities receiving LTSS. Section 2.07 of the Model Contract describes the Bidder's coordination responsibilities.

The Bidder uses existing data and analytic capacities to identify the changing needs and risks of members; stratify members' needs according to acuity and risk for hospitalization or nursing home placement, communicate with care teams regarding high risk members, and ensure that members receive appropriate, timely and comprehensive care management services. The ability to modify members Plan of Care to ensure the appropriateness and authorizations of service is an essential component. The Bidders applies systems, science, and information to identify members with potential care management needs and assist members in accessing care management services with the goal of improving or maintaining their health.

The Lead Care Manager is responsible for monitoring and ensuring the quality and effectiveness of care management activities in multiple ways, including through coordination with primary care providers, community health and social service resources, other entities providing integrated care management services or **CurrentCare**, if data is available. The effectiveness of the care management process is measured by the review and analysis of patient outcomes. The Bidder is expected to develop processes to collect and submit population based measures to the State annually for review in a manner and format prescribed by the State.

Management of Care Transitions

Success of this program depends on the ability to manage the transition of members 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 members move between care settings and levels of care. A key in care transitions is to have effective strategies that prevent members from moving to a higher level of care, when it is avoidable.

To successfully transition a member across settings, Care Management and support during transitions must be available twenty four hours a day, seven days a week (24/7). This includes a transitional Care Management program that provides onsite visits with the Care Manager upon discharge from hospitals, nursing homes, or other institutional settings. Care Managers will assist with the development of discharge plans. Transitional Care Management reflects Rhode Island'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.

Analysis of Care Management Effectiveness, Appropriateness and Patient Outcome

The Lead Care Manager is responsible for monitoring and ensuring the quality and effectiveness of care management activities in multiple ways, including coordination with primary care providers, community health teams, or other entities providing integrated care management services. Each member with care management needs must have a Plan of Care to addresses his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self direction.

The effectiveness of the care management process is measured by the review and analysis of patient outcomes. The CCE will develop processes to collect and submit population based measures to State annually for review in a manner approved by EOHHS. State approved measures are used to monitor success.

The Bidder is expected to have integrated electronic information systems to provide care managers with access to all essential data related to the member (including but not limited to: member's clinical history, diagnosis, sentinel events, urgent/on-going care need), other data sources (pharmacy, utilization) and data mining tools (risk profiling, risk scores) to: (1) place a member into his/her appropriate care management model (for that particular date in time); (2) implement his/her Plan of Care; (3) monitor Plan of Care for effectiveness and appropriateness; and (4) modify the Plan of Care to accurately reflect any change in the member's circumstances. Strong consideration should be given to the use of the State's Health Information Exchange, **CurrentCare**, to support information exchanges, particularly around transitions of care. The Bidder is required to communicate personal health information via a secure electronic portal such as Health Information Services Program (HISP).

3.10 Nursing Home Transition Members, including *Rhode to Home* Participants

The State establishes policies, procedures and practices for Medicaid recipients who, upon

conclusion of participation in the Nursing Home Transition Program (NHTP) or the Money Follows the Person referred to as the *Rhode to Home* demonstration grant, will be transitioned to the CCCCCP program.

The Procurement Library contains the NHTP description and the CMS approved *Rhode to Home* MFP Operational Protocol that the Bidder must be familiar with. The following describes the process flow related to the NHTP and *Rhode to Home* demonstration grant.

Rhode to Home Eligibility

Eligibility for the *Rhode to Home* demonstration is regulated by Federal demonstration requirements and final approval of all potential *Rhode to Home* enrollees is conducted by EOHHS. A member 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 paid by Medicare);
- Be Medicaid eligible (at least one day immediately prior to discharge); and (1) once the above criteria have been met, the State must inform the member about the *Rhode to Home* demonstration grant, and (2) obtain an informed consent to participate in the *Rhode to Home* Demonstration which is signed by the member or their legal guardian (if applicable);
- The State reviews and approves a list of all potential *Rhode to Home* participants that meet the initial enrollment criteria outlined above. EOHHS establishes all reporting requirements for initial enrollment; and
- Members that meet all initial enrollment criteria and have been verified by the State as eligible for enrollment will be deemed “*Rhode to Home* Enrollees”.

The specific criteria to determine a member’s eligibility to participate in the *Rhode to Home* demonstration grant include:

- The member must move to a *Rhode to Home* qualified residence that meets the requirements established by the EOHHS. The qualified residences include: (1) an individual’s home, or apartment like setting that includes areas for sleeping, bathing, living and kitchen, (2) the home or apartment must be owned or leased by the individual or their caregiver or family member; and (3) the home may be a group home where no more than four individuals reside;
- Additional qualifying criteria may 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 Plan of Care, 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;

- Members that meet all participation criteria and have been verified by the State as eligible for participation will be deemed “*Rhode to Home* Participants”; and
- EOHHS determines when an individual’s participation in the *Rhode to Home* demonstration grant ends.

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

The State receives referrals from the nursing facility 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. The State utilizes the information to identify individuals who are interested in receiving Long Term Care Options Counseling (LTC Options Counseling).

LTC Options Counseling

The State coordinates with the State’s Aging and Disability Resource Center (ADRC) to ensure that LTC Options Counseling is provided to members who were referred through the MDS Section Q process as well as other independent referrals received for individuals living in institutions as well as 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; and (2) utilizes materials and supports established by and/or approved by the State.

Nursing Facility Referrals

The State reviews data provided through the MDS 3.0 Section Q to identify those individuals that have resided in a nursing home or other specified institutions that are likely candidates to transition to a community based residence and could potentially receive community based care. The State conducts a screen of potential candidates who desire to transition to a community based residence and may be eligible to receive HCBS.

- The State documents all members assessed, the potential ability to transition, barriers to potential transition, and any additional criteria established by the State.
- A Plan is developed to provide LTC Options Counseling and information for potential transition to a community-based residence.
- Other information is reviewed such as, but not limited to: the patient’s length of stay in the nursing home, 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.
- The State determines if the member meets the eligibility criteria for the NHTP or *Rhode to Home* participation.

Transitioning Process to a Community-Based Residence

The State designates a Transition Team to ensure the following process occurs:

- **Conduct a Comprehensive Clinical Assessment** that includes but is not limited to: a clinical assessment conducted by a nurse, a social services assessment containing a psychosocial evaluation, and a risk assessment.
- **Develop a Person-Centered Plan of Care** to address all of the individual's LTSS needs that will be provided once they transition to a community based residence. The person-centered Plan of Care includes but is not limited to 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 three hundred sixty-five (365) days after the date of transition for *Rhode to Home* participants and for a minimum of ninety (90) days for NHTP enrollees. Care Management is provided in a manner that meets the individual's varying medical and non-medical needs. The State maintains care management policies, procedures and practices and has systems in place to track and document the provision of services and care management provided to members throughout transition process.

The State is required to conduct a 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 during the first month of transition with a minimum of two (2) face-to-face visits, and (3) monthly visits and/or phone contact beginning month two (2) through twelve (12) after the individual transitions to a community based residence. For *Rhode to Home* Participants, monthly visits and/or phone contact continues until the State determines the individual's end date of *Rhode to Home* participation. The frequency of face-to-face visits or phone contact occurs with members based on their individual needs.

The transition coordination and care management period begins once the member transitions to a community based residence and lives in the residence. For *Rhode to Home* participants, a member's transition period may extend beyond 365 consecutive days if the individual experiences an interruption in their community support services due to hospitalization, critical incident, or other extenuating circumstances. For NHTP enrollees, the transition and care management period is provided for a minimum of ninety (90) days once the member transitions to a community based residence.

The care management process also includes, but is not limited to, assessing the member'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) and help acquire such services as needed are met so that members have the ability to live safely and independently in the community.

- **Ongoing Care Management** is provided by the State once the individual completes the Transition Coordination and Care Management period outlined above. The State begins providing ongoing care management as established in the prior Section 3.9.
- **Quality of Life** surveys must be conducted for all members 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.

The State contracts with the Alliance for Better Long Term Care to perform Quality of Life surveys for all approved *Rhode to Home* transition cases, in the manner established by the State and utilizing the Quality of Life survey tool approved by the State. For those transitions that are not approved *Rhode to Home* cases, the State will conduct the Quality of Life surveys.

For members 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.

Additional Services

The State provides Peer Navigator/Peer Mentor services to meet the needs of *Rhode to Home* participants who require assistance and peer mentoring to access community services. Peer Navigator/Peer Mentor services may be provided to individuals with physical disabilities; who are elderly; who have a history of homelessness; who have been identified as a veteran; with intellectual or developmental disabilities, and other possible specialized needs that may be identified on an individualized basis.

The State uses the LTC Ombudsman to serve as an advocate for transitioning members.

Critical Incidences

The State has established processes for reporting on all critical incidents such as: hospitalizations, emergency room visits, medication errors, physical abuse, neglect, self-neglect, financial exploitation, police involved incidences, and disasters that result in recipients that are displaced from their homes. EOHHS establishes the requirements for incident documentation, review, and ongoing monitoring process. The State reviews all critical incidents as they are reported to ensure the member remains safe in their home environment including the circumstances surrounding the critical incident and the continued needs of the member. For NHTP participants, EOHHS reviews and monitors critical incidents that impact the individual during their transition coordination and care management phase.

For *Rhode to Home* participants, the State currently contracts with the Alliance for Better Long

Term Care to report all critical incidents such as: hospitalizations, emergency room visits, medication errors, police involved incidences, and disasters that result in recipients that are displaced from their homes.

The Bidder shall assume the responsibilities of the Alliance for Better Long Term Care for members who have transitioned from the NHTP and the *Rhode to Home* demonstration to the CCCCCP program.

Home and Community Care Emergency Back-up Plan

For members transitioning from an institutional setting to a home and community based setting, the Transition Team must establish an Emergency Back-Up Plan that will provide support to the individual. The Back-Up Plan identifies key people or agencies that the member 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 Team may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual.

For *Rhode to Home* Participants, the Emergency Back-Up Plan provides services and supports twenty-four hours per day and seven days per week. The Alliance for Better Long Term Care functions as the third or final level of back up in emergent situations as established by the Transition Team. In this role, the Alliance for Better Long Term Care will work with the member in determining the severity of their situation, identify the steps the member took prior to calling the Alliance and provide necessary services or support to meet the member's needs. The Alliance for Better Long Term Care will continue to report to the State actionable occurrences under the Emergency Back-Up Plan.

The Bidder will be responsible for developing the Emergency Back-Up Plan, providing the services now rendered by the Alliance for Better Long Term Care, and meeting the Emergency Back-Up and critical incidence requirements for those members who have transitioned to the CCCCCP program from the NHTP or the *Rhode to Home* demonstration project. The Bidder has policies, procedures and practices that are approved by EOHHS to provide the functions meet related to reporting of critical incidences and to the Emergency Back-Up Plan and capacity of member needs.

Affordable Housing

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

- Affordable apartment units listed thin Public Housing Authorities;
- Tenant-based rental assistance and voucher programs;
- Opportunities for members to reside in a home or apartment with a caregiver or family member;

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

The State's Social Caseworker with housing expertise assist members who are interested transitioning from a nursing home to a community based residence. The Social Caseworker with housing expertise utilizes resources of affordable housing options available to individuals across the State. Resources 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 Social Caseworker with housing expertise discusses with members varying housing alternatives and assists the member choose a suitable residence that is safe and meets their needs. The Social Caseworker with housing expertise works with the Transition Team in assessing the suitability of housing options.

The Social Caseworker with housing expertise has 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 fair housing regulations, tenant-landlord rights and reasonable accommodation requests. Additionally, the Social Caseworker with housing expertise is familiar with community based long term services and supports, that can be provided in the varying housing models to help support individuals residing in the community.

3.11 Member and Provider Services

The Bidder must meet the requirement in Section 2.10 and 2.11 regarding Member and Provider Services, respectively.

The Bidder staffs a Member Services function to be operated at least during regular business hours (8 AM to 6 PM including lunch, Monday through Friday) and to be responsible for the functions identified in the Model Contract. The Bidder maintains a toll-free Member Services telephone number that is staffed during regular business as noted above, to provide information to members.

Once a year, Contractor must notify members in writing of their rights to request and obtain information about: their benefits, non-covered services, coordination of benefits, freedom of choice provider restrictions, State Fair Hearing process, complaint process, after hour and emergency coverage, services authorization requirements, referrals for specialty or behavioral health care, and other information as identified in Section 2.10 of the Model Contract.

Bidder must ensure that the Bidder's services are provided in a culturally competent manner to all members.

The Bidder has an ongoing program of provider education concerning CCCC*P* program and the needs of the member population. The provider education program includes a quarterly provider newsletter. The Bidder submits all member and provider materials to the State for review and approval.

3.12 Care Management and Quality Assurance

The State is responsible for the overall Medical Management and quality assurance, or quality management (UR/QA) functions. The Bidder, therefore, complies with all EOHHS UR/QA standards, in addition to specific standards described in this section. A health care professional who has the appropriated clinical expertise in care management may make a recommendation to authorize a service on the basis of Medical Necessity in an amount, duration or scope or a recommendation that is less than the current authorized amount. The State approves all authorizations for services.

The requirements for care management and quality assurance is described in Section 2.12 of the Model Contract and highlighted below.

Program Director

The Bidder designates a Program Director responsible for the CCE activities outlined in the model contract. The Program Director shall be responsible for the development, implementation, and review of the internal quality assurance program (QAP). The Program Director is licensed to practice in the State of Rhode Island and trained in his or her field of specialty. The Program Director is responsible for:

- The Bidders Care Management Protocols
- Development of Quality Management collection and reporting
- Overseeing the investigation of all potential quality of care problems
- Development of Contractor's performance and outcomes reporting and policies
- Adherence to corrective action plans, if needed
- Coordination with Health Home State Plan Amendment activities, as required
- Oversight of Medication Reconciliation activities

The Program Director is involved in: (1) recruiting and hiring activities, (2) the process for care planning and coordinating service authorization, (3) the development and oversight of the Contractor's care management programs, (4) the process for ensuring the confidentiality of medical records/client information, and (5) the process for ensuring the confidentiality of sexually transmitted infection (STI) appointments and mental health and substance abuse appointments. The Administrator of the EOHHS OLTSS oversees the contract and is the primary EOHHS contact. The Program Director serves as the Bidder's liaison with the Connect Care Choice participating practice sites and CCC Nurse Care Manager, the provider community, the Medicaid Program, including the OCP staff, EOHHS agencies and designees, and the Medicare program.

Utilization Review

The Bidder agrees to have written policies and procedures to track and monitor utilization of services by its members and to assure the quality and accessibility of care being provided. The policies and procedures; (1) conforms to 42 CFR 438.350, (2) participates in the EOHHS SURS and QA Committees meetings on a regular schedule, (3) provides for regular UR/QA oversight reporting to the State management and providers.

The policies and procedures include protocols for tracking coordination of prior approvals for services, referrals for services, coordination of hospital discharge planning, coordination with Medicare providers and retrospective review of claims. The Bidder includes as part of the protocol tracking of annual and life-time financial and utilization limits related to specific services. The Bidder is expected to at minimum to coordinate the limits for minor assistive devices and home modifications.

The State is responsible for the approval or denial of Medicaid covered services. Medicare is responsible for the approval or denial of Medicare covered services.

Quality Assurance

The Bidder has written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of social services.

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 the EOHHS, or its designees, as requested, at least within thirty (30) days. The Bidder will cooperate fully with the 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 the Bidder and EOHHS and provides Medicaid HEDIS[®] and CAHPS[®] results to 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).

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, records for review of quality of care and access issues.

Practice Guidelines

The Bidder is not required to develop (or adopt) and disseminate practice guidelines that comply with 42 CFR 438.236. However the Bidder is required to adopt “best practices” to improve the accessibility, integration/coordination and quality of care as well as the efficiency and effectiveness of administrative functions

Service Provision

In accordance with approval by the State, the Bidder coordinates 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. For Medicare funded services, the Bidder coordinates the Medicaid wrap around services, as authorized by the State.

Provider Credentialing

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

The State does not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

3.13 Operational Data Reporting

Operational data reporting is a core responsibility of the Bidder under this LOI. The Bidder must comply with Section 2.13 of the Model Contract. There are four major categories for the operational reporting requirements: (1) reporting of Bidder’s care management activities for CCCCPC members; (2) reporting on the activities for all members enrolled in the CCCCPC; (3) reporting on the utilization of services by CCCCPC members; and (4) collecting and reporting on the quality measures from CCC practices sites for CCCCPC members. The Bidder provides EOHHS with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to the State.

Reporting of Bidder’s Care Management Activities for CCCCPC Members

The Bidder agrees to submit care management quarterly information in a format that is approved by EOHHS.

Reporting on the Activities for All Members Enrolled in the CCCCPC

The Bidder agrees to: (1) submit a quarterly complaints report due no later than thirty (30) days after the end of the reporting quarter, (2) submit a quarterly report on referrals to the State Fair Hearing process and to Medicare appeals process (3) submits internal quality assurance reports

periodically, (4) collect member satisfaction data through a annual CAHPS survey, and (5) submit a quarterly members services report due no later than thirty days after the end of the reporting period. The Bidder also reports critical incidences for members who have transitioned from NHTP or the *Rhode to Home* demonstration project to the CCCCCP program.

Reporting on the Utilization of Services by All CCCCCP Members

The Bidder agrees to accept the CCCCCP member utilization data furnished by the State. The Bidder agrees to provide, for each member, 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 members at such intervals as required by EOHHS. The Bidder submits data in an electronic format that conforms to the State's specifications. The Bidder submits person-level records to the State in a manner prescribed by the State.

Collecting and Reporting on the Quality Measures from CCC Practices Sites

The Bidder agrees to collect the quality measures from the CCC practice sites for the CCCCCP members enrolled in the CCC practice in a manner a prescribed by the State.

The CCE's Program Director must certify all the data submitted to EOHHS. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness data or documents submitted.

3.14 Grievance and Appeals

The Bidder must meet the requirements governing the grievance and appeals process as described in Section 2.14 of the Model Contract.

The State has established a Fair Hearings system through which Medicaid members can seek redress of grievances or appeals. The Bidder shall have policies and procedures to assist members on the process for filing a Fair Hearing with the State, including the right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member. For Medicare funded services, MME members access the Medicare appeals process. The Bidder shall have policies and procedures to assist the MME member on the process for filing a Medicare appeal, including the right to a Medicare Appeal, how to file an Appeal, and representation rules at an Appeal must be explained to the member.

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

3.15 Payment to Bidder

The Bidder accepts the capitation rates as contained in the Model Contract. The State makes Capitation Payments to the Bidder on a monthly basis via electronic funds transfer as described

in Section 3.04 of the Model Contract.

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). The Bidder is expected to make every effort to identify TPL to the fullest extent possible to assure that other funds are used before Medicaid funds are expended, including but not limited to: (1) identifying potential other TPL when a member initially is enrolled and periodically thereafter, (2) identifying other potential TPL (e.g. auto insurers or liability insurers when acclaim is related to an accident), (3) and notifying the State Fiscal Intermediary when TPL is identified.

3.16 Financial Standards, Record Retention, and Compliance

Bidder's Financial Standards

The Bidder agrees to comply with all Rhode Island Secretary of State, Department of Business Regulation, Department of Health standards in addition to specific requirements described Section 2.16 of the Model Contract.

The success of the Rhode Island Integrated Care Initiative is contingent on the financial stability of participating Contractor. As part of its oversight activities, the State will establish financial viability criteria, or benchmarks, used in measuring and tracking the fiscal status.

The Bidder agrees to provide the information necessary for calculating benchmark levels and to continually meet the States 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

As required by Section 2.17 of the Model Contract. 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 are discussed in Section 2.18 of the Model Contract. The Bidder is required to have 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 Model Contract are submitted to EOHHS for review and approval within 90 days of the execution of the contract and then on an annual basis thereafter. Compliance is one of three component of the State's Program Integrity efforts (identification and recovery of TPL and detection and control of fraud and abuse are the other two components).

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 35 days upon request, (5) providers must to disclose any individual who has more than five percent interest in the provider who was convicted of a crime, (6) discloses to the State any individual who that more than five percent ownership who has been convicted of a crime. These requirements are more fully discussed in the Model Contract.

The Bidder is prohibited from hiring employees whose license have been suspended by the Medicare or the Medicaid program or had their license sanctioned in any state. These requirements are more fully discussed the Model Contract.

3.17 Model Contract Attachments

The Model Contract contains the following attachments which are critical components of the Integrated Care Initiative or key requisites to achieving the desired procurement results. These Attachments contain: (1) schedule of Covered Medicaid benefits, (2) schedule of Covered Medicare Benefits, (3) schedule of non-covered Medicaid services, (4) nutrition standards for adults, (5) CCC Service Locations (6) capitation rates, (7) insurance certificates, (8) rate setting process and (9) quality and reporting requirements. Bidders are urged to read the Attachments that they will be required to meet.

3.18 Model Contract Terms and Conditions

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

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

The Bidder must adopt a strategic and robust approach to the prevention, detection, investigation and reporting of potential Medicaid fraud, waste and abuse to assure that Medicaid funds are appropriately expended.

3.19 Evidenced Based Best Practices

EOHHS expects Bidders to implement evidenced-based “best practices” that have demonstrated success in advancing the goals of this procurement and the tenets of an integrated system. Best practices may be related to: improving a member’s health care status and quality of life, enhancing health outcomes; promoting a person-centered system; maintaining effective care management practices that promote integration and coordination of care; inclusion of non-traditional providers to maximize limited medical resources, effective transition management practices that provide seamless care when members move between levels of care, or enhanced member services to foster a member’s self-reliance and independence. These “best practices” may either be operating in other state programs nationally or in the Bidder’s current program.

The Appendix F outlines several best practices that are presented as illustrative examples of the types of best practices that EOHHS expects Bidder’s to consider incorporating under this procurement.

3.20 Model Contract Addendums

The Model Contract contains Addendums Bidders that cover specific and critical requirements that Bidders are expect to meet. These requirements are related to: (1) fiscal assurance, (2) notice to EOHHS providers of their responsibilities under Title VI of the Civil Rights Act of 1964, (3) notice to EOHHS providers of their responsibilities un 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 the debarment, suspension and other responsibility matters primary covered transactions, (10) liquidated damages, (11) equal employment opportunity, (12) Byrd anti lobbying amendment, (13) bid proposal, (14) core staff positions, (15) federal subaward reporting, and (16) business associate agreement.

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

CHAPTER FOUR: PROPOSAL SUBMISSION REQUIREMENTS

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 Pre-Bid Conference

No pre-bid conference shall be conducted.

4.2 Submission of Questions

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 # 7461250 Coordinating Care Entity for Connect Care Choice Community Partners Program under the Medicaid Integrated Care Initiative** 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.

4.3 Procurement Library

For more detailed information regarding the Rhode Island Medicaid Program, see the following Procurement Library at the following web-site:

<http://www.ohhs.ri.gov/integratedcare/newsandupdates/> .

The following documents are available in the Procurement Library.

Connect Care Choice

- Program description of Connect Care Choice and Fact Sheet
- Connect Care Choice practice sites
- Role of Nurse Care Manager
- Co-Located Behavioral Health services

Long Term Services and Supports (LTSS)

- Awareness of and Need for Home and Community Based Services for Rhode Island Adults on Medicaid “Snapshot” Survey Results
- EOHHS/Medicaid Nursing Home Reimbursement Methodology Overview
- Maintaining Community Residence for People with Long Term Care Needs: A Literature Review of Factors Associated with Physical Decline, Cognitive Decline, and Nursing Home Placement
- Rhode Island Nursing Facility Payment Method Policy Design Document
- Rules and Regulations for Licensing Home Nursing Care Providers and Home Care Providers

Personal Choice Program (Self-Direction)

- RI Medicaid Personal Choice Program Rules and Regulations
- Checklist for Managed Care Organizations Implementing Participant-Directed Service Options
- Developing and Implementing Self-Direction Programs and Policies: A Handbook
- Participant Direction in Managed Care: Center for HealthCare Strategies August Call 2012
- Participant-Directed Roles and Responsibilities

Rewarding Work

- Rewarding Work (www.rewardingwork.org) is a website that provides an online registry of personal care assistants/individual support providers to people with disabilities and/or their families
- Rhode Island 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.

Assisted Living

- Medicaid Assisted Living in Rhode Island: Evaluation of Payment Methods

Rhode to Home Money Follows the Person (MFP)

- Money Follows the Person Operational Protocol for the Rhode Island: The *Rhode to Home* Demonstration Project

Nursing Home Transition Program

- Nursing Home Transition Program policies and procedures
- Role of the OCP Nurse Care Manager

RItE @ Home

- RIte @ Home... A Choice for Care @ Home: Program Standards

Safe Transitions

- Improving Care Transitions for Rhode Island Patients

Health Home

- Section 2703 of the Patient Protection Affordable Care Act offers states the opportunity to pursue a Health Home
- Federal support is available to enhance the integration and coordination of primary, acute, behavioral health and long-term care services and supports for Medicaid enrollees with 2 or more chronic conditions listed in Section 1945 (h)(2) of the Act, one chronic condition and be at risk for another, or one serious and persistent mental condition.

U.S. Department of Veterans Affairs

- Exploring New Roles for Home Care Workers
- Financial Savings of Home Based Primary Care for Frail Veterans with Chronic Disease
- Providence VA Medical Center: Home Based Primary Care (HBPC) Presentation
- Veteran's Affairs Home Based Primary Care Study
- VHA Handbook: Home-Based Primary Care Program

Rhode Island Chronic Care Sustainability Initiative

- Key Dates for CSI Patient Centered Medical Homes
- Rhode Island Chronic Care Sustainability Initiative Agreement Contract Template

Aging in Place

- Naturally Occurring Retirement Community (NORC) blueprint for aging in place
- Health Indicators and survey tools

Department of Health Programs

- RI Department of Health Falls Prevention programs
- Center for Disease Prevention programs related to Falls Prevention
- Chronic Care Programs
- ADA programs
- Living Well RI

Other Information

- Graphs on Rhode Island Long Term Care

- **CurrentCare** is Rhode Island's a secure electronic network that gives doctors and other health care providers access to your most up to-date health information right away so they can treat you with the best possible care

Additional Information

- 2012 Rate Review Process Hospital Contracting Condition
- Contract Timeline Overview
- State Affordability Standards

4.4 Proposal Submission

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.

Proposals must include the following:

1. A letter of transmittal signed by the owner, officer or authorized agent of the firm or organization, acknowledging and accepting the terms and conditions of this LOI, and tendering an offer to the State.
2. A Technical Proposal describing the background, qualifications and experience with and for similar programs, as well as the work plan or approach proposed for this LOI. The bidder shall submit only a technical proposal, a cost proposal is not necessary, the bidders are required to accept the capitation payments reflected in the model contract as appended in this LOI.

The technical proposal must contain the following sections:

1. Transmittal Letter (see above)
2. Assurances/Attestations
3. Bidder Experience and Understanding
4. Technical Response
 - A) Plan to Enroll Members and Provide Member & Provider Services
 - B) Plan to Conduct Analytic Risk Assessment and Initial Telephonic Health Screen
 - C) Plan to Establish a Community Health Team and Serve as a Lead Care Manager
 - D) Plan to Comply with the Principles of the ICC and Requirements of the CCCCCP Program
 - E) Plan to Support EOHHS with Members Transitioning from the NHTP and *Rhode to Home* demonstration to the CCCCCP program
 - F) Plan to Provide EOHHS with Operational Data Reports on Members and Program

Activities
G) Plan to Implement Evidenced-Based Best Practices

5. Additional Technical Response from New Bidders (if applicable)

Proposals (an original plus seven (7) copies) and two (2) electronic (Compact Disc or thumb drive) copies should be mailed or hand delivered in a sealed envelope marked “**LOI # 7461250 Coordinating Care Entity for Connect Care Choice *Community Partners* Program under the 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.

4.5 Response Limits

The State does not want bidders to develop excessively elaborate responses to this LOI. The Technical Proposal shall be limited to **75 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.

4.6 Technical Proposal Specifications

The following provides information on the specifications for the technical proposal, including suggested page allocations.

4.6.1 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

4.6.2 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 approved to operate within Rhode Island. The Bidder should identify any RI license it holds and from which agency or department. The Bidder should also identify certifications and accreditations it holds from State or National bodies and from which State or National body.
- **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, as reflected in the Model Contract.
- **A statement** that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidders.
- **A statement** that the Bidder accepts that an award made pursuant to this procurement between the State and the Bidder Organization.
- **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 will submit copies of their State Licenses and any State or National Accreditation Certificates with the response to this LOI.

4.6.3 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.

- State licenses held by the Bidder and the licensing authority or body.
- Certifications and accreditations held by the Bidder and the State and National bodies certifying and accrediting the Bidder.
- Experience in serving Medicaid recipients.
- Experience in serving Medicare beneficiaries.
- Experience in serving dual eligible Medicare and Medicaid beneficiaries (the MME population).
- Experience in providing services in Rhode Island.
- An understanding of the RI environment; the conditions surrounding this procurement and; knowledge of and experience with the Medicaid population in other states, as applicable.
- The capability and capacity of the Bidder to coordinate the Medicaid services to the eligible populations under this arrangement.
- The capability and capacity of the Bidder to coordinate the Medicare services to the eligible populations under this arrangement.
- The financial viability of the Bidder to operate under a capitated agreement (including prior experience operating under a capitated agreement as well as adverse factors that may affect the Bidder’s financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines).
- The ability to be ready and serve member’s by the stated contract commencement date.
- The ability to work with the State to meet the requirements of a Health Home as defined in Section 2703 of the Patient Protection Affordability Act.

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

4.6.4 Technical Response

The following describes the Technical Responses required from the Bidder.

A) Plan to Enroll Members and Provide Member & Provider Services

The Bidder should discuss its plan for enrolling the *CCCCP* 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 members effective the first day of the following month after receiving notification from the State, (3) mail notification of enrollment to members including effective date, how to access care and CCC Fact Sheets and LTSS brochures within ten calendar days after receiving notification from the State, (4) provide

orientation to new member 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) maintain a toll-free member service call line with capacity to meet the language preferences of the member (6) document and track member services activities (7) discuss the contents of materials and documents noted above, (8) supplying information to members that in a culturally and disability competent manner, (9) provide member services during normal business hours (8 AM to 6 PM including lunch Monday through Friday), (10) inform members annually about their rights, responsibilities, benefits, and program requirements, (11) inform providers about the CCCC program, and (12) other topics deemed appropriate by the Bidder.

B) Plan to Conduct Analytic Risk Assessment and Initial Telephonic Screen

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 analysis to initially identify member in need of care management through an analysis of claims data and the conduct of the initial screen, (3) the use of risk profiling models to identify the population requiring or at risk of requiring care management, (4) how it will determine who is at “risk” or will benefit from care management, (5) the models, classifications and definitions that will be used to stratify populations in terms of their need for care management by the CCC care manager, the OCP care manager, DEA care manager or the CHT care manager, (6) the identification of risk behaviors or risk conditions of members throughout the intervention process which signifies the need for care management, (7) the anticipated benefits of risk profiling, (8) the time schedule for operating a comprehensive risk-profiling and early identification system, and (9) other topics deemed appropriate by the Bidder.

The Bidder should also discuss its plan to conduct the Initial Telephonic Health Screen. Specifically the Bidder should describe: (1) the number, type, and experience of staff conducting the Screen, (2) the policies, procedures and practices that will be used in the Screen, (3) the instrument and protocols that will be used in conducting the Screen, (4) the information and formats that will be used to document the Screen, (5) the criteria and procedures that will be used to classify members into Level I and Level II and to meet State requirements, (6) the proposed information and formats the will be used to report to EOHHS about the Screen, and (7) other topics deemed appropriate by the Bidder.

C) Plan to Establish a Community Health Team and Serve as a Lead Care Manager

The Bidder should discuss its plan to establish a Community Health Team (CHT). Specifically the Bidder should describe: (1) the number, type, and experience of staff who will compose the CHT, (2) how the Bidder proposes to meet the responsibilities and roles of the CHT, (3) proposed policies, procedures and practices that involved in the creation and operation of the CHT, and (4) other topics deemed appropriate by the Bidder.

The Bidder should also discuss its plan for when a member of the CHT serves as the Lead Care Manager. Specifically the Bidder should describe: (1) its understanding of when a member of the CHT will serve a Lead Care Manager, (2) the characteristics and needs of the members who the CHT Lead Care Manager will likely serve, (3) the criteria that will be used to assign a Lead Care Manager, (4) the policies, procedures and practices that will be used in fulfilling Lead Care Manager responsibilities, (5) the suggested caseload for serving as a Lead Care Manager, (6) the amount of telephonic and face-to-face contact the Lead Care Manager will have with members. (7) proposed reporting of Care Management activities and results, and (8) other topics deemed appropriate by the Bidder.

D) Plan to Comply with the Principles of the ICC and Requirements of the CCCCCP program.

The Bidder should discuss its plan to comply with the Principles of the ICC and Requirements to Comply with Requirements of the CCCCCP program. Specifically the Bidder should describe: (1) staffing and proposed organizational functions to be performed including FTE levels by functional area, (2) how it will meet the principles of the ICC and the CCCCCP program, (3) how it will comply with a person-centered system, (4) its understanding of the services and Medicaid benefit structure, (5) how it will interface with the entire care management process including, but not limited to the: Comprehensive Needs Assessment; Provider Network including the PCP; Plan of Care; Multi-Disciplinary Team; Designated Lead Care Manager; coordination and integration of services and care; conflict-free care management; transitioning members from care settings; and analysis of care management effectiveness, appropriateness, and patient outcomes, (6) compliance with quality assurance, (7) understanding of the NHTP and *Rhode to Home* demonstration grant, (8) compliance with quality assurance (9) compliance with grievance and appeals process, (10) acceptance of capitated payments and TPL requirements, (11) Financial standards, record retention, and compliance, (12) acceptance of model contract amendments, (13) compliance with model contract terms and conditions, and (14) other topics deemed appropriate by the Bidder.

E) Plan to Support EOHHS with Members Transitioning from the NHTP and *Rhode to Home* demonstration to the CCCCCP program.

The Bidder should discuss its plan to comply with the Principles of the ICC and Requirements to Comply with Requirements of the CCCCCP program. Specifically the Bidder should describe: (1) the policies and procedures of reporting of critical incidences, (2) will this function be performed by the Bidder's staff or sub-contracted with another company/organization and with whom, (3) the policies, procedures and instruments that will be used to develop and maintain Emergency Back-Up Plans, (4) will this function be performed by the Bidder's staff or sub-contracted with another company/organization and with whom, (5) how will the Bidder ensure that the Back-Up is viable on an ongoing basis and who will serve as the last level for emergencies, (6) what is the staffing that will be employed to perform these activities, and (7) other topics deemed appropriate by the Bidder.

F) Plan to Provide EOHHS with Operational Data Reports on Members and Program Activities

The Bidder should discuss its plan to comply with the Principles of the ICC and Requirements Comply with Requirements of the CCCCCP program. Specifically the Bidder should describe: (1) reporting of Bidder's care management activities for CCCCCP members, (2) reporting on the activities for all members enrolled in the CCCCCP, (3) reporting on the utilization of services by all CCCCCP members, (4) collecting and reporting on the quality measures from CCC Practices Sites, and (5) other topics deemed appropriate by the Bidder.

G) Plan to Implement Evidenced-Based Best Practices

The Bidder should describe its plan for implementing evidenced-based best practices that are nationally recognized or from the Bidder's own program. Best-practices relate to, but not limited to: (1) enrollment practices, (2) member services, (3) risk profiling, (4) person-center system, (5) establishment of a multi-disciplinary care management team (6) care management practices as related to the provision of social services and "peer mentoring" services, (7) the coordination and integration of medical, behavioral health, LTSS and social services, (8) development and execution of Emergency Back-Up Plans and reporting of critical incidences, (9) collection of operational data and reporting findings, and (10) other topics deemed appropriate by the Bidder.

4.6.5 Further Clarification of Proposals and Oral Presentations

The State reserves the right to ask parties submitting proposals to provide additional information or clarification about their proposal in writing, verbally or both. The State may interview representatives of parties submitting proposals or ask them to conduct oral presentations about their proposals. The State also may request an on-site tour and inspection of facilities and operations of parties submitting proposals.

4.6.6 Bid Amendments

It may be necessary for the State to issue amendments to these bid specifications prior to awarding contracts. If this occurs, bidders will be provided with instructions on how to modify their proposals as necessary to accommodate the bid specifications amendments and will be given reasonable time in which to formulate a response.

4.7 Evaluation Committee

The State will commission a Technical Review Committee, which will evaluate and score all proposals. Only State Personnel will serve as voting Members of the Technical Review Committee. However, the State may designate other individuals to serve as staff to the Technical Review Sub-Committee and to provide assistance in its evaluation activities.

4.8 Evaluation Process

The State will conduct a comprehensive and impartial evaluation of all bids. The technical proposals will be evaluated against a set of minimum standards to identify any proposals that are incomplete or unresponsive. The State, through its Technical Review Committee, will be the sole judge in reviewing proposals and awarding contracts.

The State will evaluate and score all proposals using the following criteria:

- **Provision of Required Information and Assurances/Attestations (Pass/Fail):** Bids will be evaluated to determine whether the bidder provided the necessary information in the Transmittal Letter and that all the Assurances/Attestations have been completed.
- **Experience and Understanding from All Bidders (20 percent):** The Bidder's experience and understanding will be evaluated based on the response to the specific information requirements noted for each topic discussed in Section 4.6.3 of this LOI.
- **Technical Responses (80 percent):** The Bidders shall provide responses for each of the proposal sections listed in Section 4.6.4. Responses for each section will be evaluated based on the specific information requirements noted for each section discussed in Section 4.6.4 of this LOI.

4.9 Contract Award

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

The State reserves the right to disqualify or not consider any proposal that is determined not to achieve the State'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 further considered.

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.

4.10 Readiness Review

The State reserves the right to conduct a "readiness review" of any bidder to assure that they are able to implement and administer the proposed terms as required in the model contract and as described in this document.

4.11 Debriefing

Unsuccessful Bidders may, within thirty (30) days of the receipt of intended contract award, request a meeting for debriefing and discussion of their bids by contacting the Issuing Officer in writing. Debriefing will not include any comparisons of unsuccessful bids with other bids. Debriefings will not be held until after the contract(s) are signed and approved by all appropriate State and Federal agencies.