APPENDIX E – Mandatory Responses to Technical Components of the RFP

1. Organization Overview and Overview of Relevant Experience

Section 1 Point Allocation	
Question(s)	**Points**
1	7
2	18
3-6	40
7-9	5
Total	70

1.1. Corporate Overview

Q1. Include in the Proposal a summary of the Respondent's organization, management, and history and how the Respondent's experience demonstrates the ability to meet DHHS's needs, as described throughout this RFP and DMCM Model Contract. At a minimum, the response should include the following information:

1) A general overview of the Respondent organization;

2) Information regarding the Respondent organization's ownership and subsidiaries;

3) Information regarding the Respondent organization's background and primary lines of business;

4) The number of employees employed by the Respondent;

5) The Respondent organization's headquarters and satellite locations;

6) The Respondent's current project commitments;

7) The Respondent's major government and private sector clients; and

8) The Respondent's mission statement.

1.2. Managed Care Experience and References

Q2. Provide a list of all current and/or recent (within five (5) years of the issue date of this RFP) contracts for managed care services (e.g., dental care, Early and Periodic Screening, Diagnostic

and Treatment services (EPSDT), Care Management and Care Coordination services), Include in a table the following information for each identified contract:

1) The Medicaid population(s) served (e.g., children, parents, non-elderly and non-disabled, Aged, Blind, Disabled);

2) The number of enrollees, by health plan type and population type;

3) The name, address telephone number and website of the client;

4) The specific start and end dates of the contract;

5) A brief narrative describing the role of the Respondent organization and the scope of work performed, including covered services;

6) The use of administrative and/or delegated Subcontractor(s) and their scope of work;

7) The annual contract amount (payment to the Respondent) and annual claims payment amount;

8) Whether the contract was/is capitated, fee-for-service, or another payment method (if another payment method, the method should be described);

9) The scheduled and actual completion dates for contract implementation and – if applicable – any boundaries that hindered implementation and the solutions employed to address those challenges; and

10) The accomplishments and achievements the Respondent wishes to highlight.

Q3. Indicate four (4) prior engagements to be used as references, for which: at least two (2) should be state agencies, preferably state Medicaid agencies. Highlight in the response examples that demonstrate the Respondent's experience with the key priorities indicated by DHHS throughout the DMCM Model Contract and noted in Section 2.1.2 (Objectives of the DMCM Program) of the RFP. The Respondent may *not* submit a reference that is employed by the State of New Hampshire. DHHS intends to contact these references and consider the information obtained as part of the scoring process. By submitting the references, the Respondent is specifically authorizing DHHS to contact them regarding this procurement, their Proposal, and any and all information the reference has regarding the Respondent. To the extent a written authorization or release is required by any reference provider, the Respondent agrees to provide one upon request. For each selected reference, the Respondent should include the following information:

1) The type of reference (e.g., state Medicaid agency, Provider);

2) The reference's name, title, and employer (again, the reference may not be employed by the State of New Hampshire)

3) The reference's contact information, including phone number, email address, and physical address;

4) The nature of the relationship, including the capacity in which the reference is familiar with the Respondent organization;

5) The time period of the relationship; and

6) Activities undertaken during the engagement that establish the Respondent's qualifications for this RFP.

Q4. Identify and describe all instances of non-compliance that the Respondent, its parent organization, and its affiliates have encountered as part of any Medicaid managed care contracts within the past three (3) years. For each non-compliance issued, the Respondent shall indicate the type of non-compliance issued, the date the non- compliance was issued, and the reason the non-compliance was issued, the issuing state(s) in which the Respondent was providing services for which the non-compliance was issued, and any and all details of the sanctions applied against the Respondent as a result of non-compliance.

Q5. Respondent shall identify any and all instances of non-renewal or early termination of contracts with states. The Respondent shall specify the type of contract, why the termination was initiated, and by whom it was initiated (contractor, state, mutual, or federally imposed).

Q6. For purposes of responding to Question 4 and Question 5, types of non-compliance include: compliance letters (includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans (CAPs) or similar state notices); adverse performance audits (contracts failing more than fifty percent (50%) of audit elements); adverse financial audits (adverse opinions or disclaimed reports); failures to maintain fiscally sound operations (negative net worth or financial loss greater than half of the contractor's total net worth); exclusions enforcement actions (imposed by CMS as an intermediate sanction); and all other significant compliance concerns.

Q7. Submit an organizational chart and a staffing plan for the MCM program. The organizational chart and staffing plan should clearly indicate how the Respondent plans to meet all DMCM Model Contract staffing requirements.

Q8. Describe the Respondent's intended on-site presence in New Hampshire.

Q9. For Key Personnel currently on staff with the Respondent, as described in the DMCM Model Contract, please provide the name, title, qualifications, and resume for each individual. For staff to be hired, please describe the hiring process and the qualifications for the position and include the job description associated with each to-be-hired employee. DHHS reserves the right to accept or reject dedicated staff individuals.

2. Subcontractors

Section 2 Point Allocation	
Question(s)	**Points**
10(1) through (3)	10
10(4) through (11)	15
Total	25

Q10. Please indicate whether the Respondent intends to Subcontract with any Subcontractors to perform portions of the obligations described in the DMCM Model Contract, or otherwise proposed by the Respondent. DHHS reserves the right to accept or reject Subcontractors. For each function that the Respondent plans to contract with a Subcontractor for, please provide the following information:

1) (i) The portions of the work to be performed by a Subcontractor; (ii) the name, address, and location of such Subcontractor; (iii) the general terms of the Subcontractor agreement, including the amount, duration and scope of services; and (iv) how the Respondent intends to provide oversight of Subcontractor;

2) A description of the Subcontractor's experience providing those services;

3) If applicable, a description and actual copies of the relevant licenses, certifications or permits the Subcontractor has and maintains that are necessary for it to perform the services;

4) A description of how the Respondent will monitor the performance of its Subcontractors to ensure all DMCM Model Contract requirements are met;

5) Sample performance monitoring reports;

6) Sample reports showing any actions taken to improve performance and ensure positive results;

7) A description of the information or data the Respondent will exchange with its Subcontractor(s) and how that information or data will be transferred;

8) If applicable, a description of how Subcontractors are integrated with Care Management programs;

9) If applicable, a description of how Subcontractors are integrated with third-party recovery and/or fraud and abuse programs; and

10) A description of any sanctions or penalties that apply if the Subcontractor fails to perform up to the Respondent's expectations.

11) Signed letters of commitment from the Subcontractors, if applicable.

3. Covered Populations and Services

Section 3 Point Allocation	
Question(s)	**Points**
11	8
12	2
13	7
14	4
15	4
Total	25

Q11. Describe how the Respondent plans to ensure access to all required dental services described in Section 1.1 of the RFP, for all members.

Q12. Describe the Respondent's process and procedures for providing Post-Stabilization Services.

Q13. Describe the Respondent's process and procedures for coordinating and facilitating Non-Emergency Medical Transportation (NEMT) for Members.

Q14. Indicate the Value-Added Services that are not offered under the Medicaid State Plan and for which the cost of services would not be included in Capitation Payment calculations. The Respondent should indicate which Value-Added Services it plans to offer to all Members.

Q15. Describe the Respondent's experience providing In Lieu of Services, pursuant to 42 CFR 438.3, which In Lieu of Services listed in the MCM Model Contract that the Respondent will provide to MCM Members in New Hampshire if selected; and which additional services the Respondent would like to provide subject to DHHS approval.

4. Member Services

Section 4 Point Allocation	
Question(s)	**Points**
16-17	10
18-20	8
21	7
Total	25

Q16. Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the Respondent's organization and the key staff within the Member Services Department.

Q17. Describe the Respondent's call center management experience in other states and anticipated approach for the DMCM program, including:

1) The location of operations (if out-of-state, describe how the Respondent will accommodate services for New Hampshire);

2) The call center performance metrics that will be implemented including how the Respondent will meet minimum abandonment and speed of answer requirements indicated in Section 4.3.1.9 (Member Call Center) of the DMCM Model Contract;

3) The processes used for conducting the Welcome Call and early rates of success in reaching Members for such calls;

4) The way in which the Respondent will determine staffing levels;

5) The process that will be used to conduct warm transfers (including any training to be provided); and

6) The plan to ensure a single, integrated Member service line for physical and behavioral health.

Q18. In a scenario where a Member who is hard of hearing calls the Member Services Department due to trouble scheduling an appointment with a Participating Provider, describe the steps and mechanisms that the Respondent will use to identify the caller's concern and document, track, and resolve the issue.

Q19. Describe the mechanisms in place, including specific language assistance capabilities, services and supports, to help potential Members and Members with Limited English Proficiency (LEP), disabilities, special health care needs, and diverse cultural and ethnic backgrounds. Indicate

how the Respondent will identify, monitor and address cultural and linguistic disparities among Members.

Q20. Describe how the Respondent will ensure cultural competency throughout the Respondent's Participating Provider network.

Q21. Describe how the Respondent will approach the composition and processes of the Member Advisory Board (Section 4.3.5) of the DMCM Model Contract, including:

1) How the Respondent will determine and ensure that there is sufficient representation of populations covered under the MCM program; and

2) How the Respondent will accommodate Members with disabilities to ensure their full participation on the Member Advisory Board.

5. Member Grievances and Appeals

Section 5 Point Allocation	
Question(s)	**Points**
22	7
23	9
24-25	9
Total	25

Q22. Describe the Grievances Process the Respondent will use. Describe the process and timing for addressing a Member's dissatisfaction with any aspect of their care, including which staff will be involved.

Q23. Describe the process and timing for reviewing an Appeals request, including the process and timing for addressing standard and expedited appeals requests.

Q24. Provide a flowchart that depicts the process the Respondent will employ, from the receipt of the appeals request through each phase of the review to notification of disposition, including providing notice to the State Hearing Process.

Q25. Describe how data resulting from the Member Grievance and Appeals Processes will be tracked and used to improve the operational performance of the MCO.

6. Provider Appeals

Section 6 Point Allocation	
Question(s)	**Points**
26-27	15
Total	15

Q26. Describe the Provider Appeals Process the Respondent will employ, in compliance with NH standards and requirements as outlined in the MCM Model Contract.

Q27. Specify the supports and management efficiencies employed by the Respondent to ensure that Provider administrative burden is kept to a minimum, processes are clearly communicated, and inquiries are readily responded to in a timely manner resulting in a demonstrated low volume of Provider Appeals.

7. Network Adequacy for Access to Dental Services

Section 7 Point Allocation	
Question(s)	**Points**
28-29	27
30	23
Total	50

Q28. Describe existing relationships the Respondent has with relevant Providers and stakeholders in New Hampshire, if any. Which relationships does the Respondent anticipate forming?

Q29. Describe in detail how the Respondent will build a sufficient and effective network of Participating Providers that promotes Member-centered care, promotes choice of Provider, engages Member's informal support system (e.g., family caregivers), and provides care in the most integrated setting for Members. Provide a detailed example of the Respondent's approach in another state's Medicaid managed care market, addressing, if possible, how the Respondent has overcome a limited supply of Providers in rural areas.

Q30. In building the Respondent's Participating Provider network and contracting with Providers, describe how the Respondent will ensure the ability of Participating Providers to provide physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Members with physical or mental disabilities, as required by 42 CFR 438.206(c)(3).

8. Utilization Management

Section 8 Point Allocation	
Question(s)	**Points**
31, 33	15
32, 34	15
Total	30

Q31. What strategies has the Respondent employed or does the Respondent currently employ in other state Medicaid markets to contain health care spending while ensuring Members maintain access to high-quality health care services? Describe how the Respondent plans to apply these strategies and any additional or new strategies in New Hampshire.

Q32. In alignment with DMCM Model Contract requirements, describe the Respondent's approach to Utilization Management and how the approach would be modified for New Hampshire, including the Respondent's process to ensure the DO Utilization Management Program includes criteria that:

1) Are practicable, objective and based on evidence-based criteria, to the extent possible;

2) Are based on current, nationally accepted standards of dental practice and are developed with input from appropriate actively practicing practitioners in the DO's service area, and are consistent with the Practice Guidelines described in Section 4.8.4 (Practice Guidelines and Standards);

3) Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);

4) Are applied based on individual needs and circumstances (including social determinant of health needs);

5) Are applied based on an assessment of the local delivery system;

6) Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

7) Conform to the standards of NCQA Health Plan Accreditation.

Q33. Describe the processes the Respondent will implement for ED utilization review and identification of Members with high utilization.. What strategies will the Respondent implement to reduce high ED utilization? Provide statistically relevant results of initiatives employed in a program similar to the DMCM program wherever possible.

Q34. Describe the Respondent's management techniques, policies, procedures or initiatives in place or that will be in place by the Program Start Date to effectively and appropriately control inappropriate ED usage. Provide statistically relevant results of initiatives employed in a program similar to the MCM program if possible.

9. Member Education and Incentives:

Section 9 Point Allocation	
Question(s)	**Points**
35	35
36	35
Total	70

Q35. Describe the Respondent's plan for implementing at least one (1) Healthy Behavior Incentive Program , as described in the DMCM Model Contract. For each program proposed, describe:

1) How Members eligible for the program will be identified and enrolled in the program;

2) The target number of Members for the program;

3) How preferred Providers and services will be identified and communicated to Members;

4) The types of incentives that will be offered to Members (including the dollar value of cash incentives and any other incentives that will be provided); and

5) How Members will earn and lose points based on changes in behavior over a period of time.

6) The Contractor shall describe processes for capturing and storing the data necessary for qualifying activities and programs.

Q36. If applicable, the MCO should provide an example of its experience administering a Member Incentive Program for a similar population and/or with similar objectives, and include:

1) The target population for the Member incentive program;

2) How individuals were identified for participation in the Member incentive program;

3) The number of individuals that ultimately enrolled in the program, and received incentives for participation; and

4) Any statistically relevant program results, particularly those that demonstrate a change in Member behavior and/or improved health outcomes.

10. Care Coordination and Care Management: Care Coordination and Care Management are fundamental to the added value DHHS seeks through its relationship with Medicaid DCOs. DHHS is seeking responses that will clearly describe Care Coordination and Care Management strategies that are targeted at improving Member care and health outcomes, reducing inappropriate utilization of Emergency Services, addressing unmet resource needs, providing Local Care Management, and decreasing the total cost of care.

Section 10 Point Allocation	
Question(s)	**Points**
37	40
38	40
39	40
Total	120

Q37. Provide a description of the Respondent's structure and plan for Care Coordination and Care Management, type of service provided, roles and responsibilities of staff involved in the provision of each service and how Members will be identified for Care Coordination and Care Management, including:

1. A description of Care Coordination and Care Management functions;
2. A description of key activities and performance expectations;
3. A description of the process and timing for conducting a Dental Risk Assessment of every Member within ninety (90) days of the effective date of DO enrollment; the identification tools and methods that the Respondent will use for identifying the Priority Populations as required in the DMCM Model Contract;
4. A description of the Care Management that will be provided to high risk high-need individuals identified as Priority Populations including, at a minimum, the coordination of dental services including referrals to specialty dentists, , referral follow-up, , training on self-management, and assistance with meeting unmet resource needs.. The description should include the projected share of Members that will be classified as high risk and engaged in active Care Management based on the Respondent's current Medicaid managed care experience and proposed approach in New Hampshire. Please provide rationale for percentage of Members

enrolled in active Medicaid Care Management as high risk. The description should include identification for the percent and/or number of Members engaged in active Care Management, either by direct DO staff or contracted agencies or in known identified relationships with the DO;

5. A description of the qualifications and competencies of the Respondent's care managers;

6. A description of whether the Respondent will include contractual relationships, if any, that support the Respondent's ability to coordinate care, including information sharing and care planning, for a Member among multiple Providers. Include a description of the contractor(s) and role.

Q38. Describe the Respondent's competencies and approach in addressing social determinants of health as part of the initial Dental Risk Assessment.. Describe how the Respondent will identify whether the Member is in need of services that address social determinants of health and, in particular, how the Respondent will provide supports such as transportation, as described in the MCM Model Contract.

Q39. For the three (2) preceding questions, provide specific examples of how the Respondent has supported these functions in other Medicaid markets, and all results, measurable outcomes, achieved from the Respondent's applied interventions.

11. Quality Management

Section 11 Point Allocation	
Question(s)	**Points**
40	10
41-43	15
44-45	10
Total	35

11.1. Health Plan Accreditation

Q40. The Respondent shall specify its current health plan accreditation status for all markets in which it is currently participating. This shall include:

1) The name of the accrediting entity (e.g., NCQA, Utilization Review Accreditation Commission (URAC));

2) The most recent date of certification;

3) The effective date of the accreditation;

4) The type(s) and corresponding level(s) of accreditation achieved; and

5) The status of the accreditation (e.g., provisional, conditional, etc.).

11.2. Quality Assessment and Performance Improvement Program

Q41. Describe the Respondent's plan for establishing and implementing an ongoing QAPI Program inclusive of all elements specified in the DMCM Model Contract.

Q42. Provide an organizational chart that indicates what the relationship of the QAPI program would be to Respondent leadership, and how the Respondent's QAPI program relates to the Respondent's processes for Utilization Management, the development and implementation of clinical Practice Guidelines, Provider relations, etc.

Q43. Provide one or more detailed examples of how, in another Medicaid managed care market, the Respondent's QAPI program was utilized to identify a necessary improvement, implement an initiative designed to address the challenge, modify the initiative based on ongoing assessment. Describe statistically relevant outcomes achieved as result of implementing the improvement.

Q44. Provide the Respondent's most recent two (2) years of Medicaid Managed Care results for all available HEDIS and CAHPS quality measures required by DHHS, as described in Exhibit O of

the DMCM Model Contract (*note: HEDIS and CAHPS measures are a subset of the measures included in Exhibit O; DHHS is not requesting all measures and reports described in Exhibit O for purposes of responding to this question)*. This information should be conveyed in a table, broken out by Medicaid managed care plan, and include the following information:

1) The name and location of the plan;

2) The total membership of the plan; and

3) A description of the population reflected in the results.

Q45. If, in response to the previous question, the DO is unable to provide Healthcare Effectiveness Data and Information Set (HEDIS) results for at least three (3) Medicaid contracts, the Respondent should provide commercial HEDIS measures for the Respondent's largest (in number of lives) contracts. If the Respondent is located in New Hampshire, New Hampshire-based results should be prioritized for inclusion in the Respondent's Proposal over larger, out-of-state contracts.

12. Network Management

Section 12 Point Allocation	
Question(s)	**Points**
46	70
Total	70

Q46. Ongoing Provider support is important to ensuring Members' access to and the delivery of high-quality care. DHHS is committed to improving the Provider credentialing process. Please describe the Respondent's proposed approach for:

1) Conducting Provider outreach and communications when programmatic changes are made;

2) Meeting the Provider training requirements as required in the DMCM Model Contract;

3) Implementing a prompt and accessible credentialing and re-credentialing process that will be used to conduct outreach and supports to Providers (note: DHHS's requirement is that all PCP Providers be credentialed within thirty (30) days and all specialty Providers be credentialed within forty-five (45) days);

4) Standardizing work processes between DHHS and Participating Providers ensure efficient implementation of theD MCM program and minimal Provider burden relative to claims billing processes, reporting, prior authorizations, etc.; and

5) Providing technical assistance to Participating Providers, especially for Participating Providers with which the Respondent would be implementing high- priority interventions (e.g., with Provider participants in MCO Alternative Payment Models).

13. **Alternative Payment Models:** DHHS is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization, and also recognizes that there is not a "one size fits all" approach to implementing APMs for the Dental Providers that serve DMCM Members. As indicated in Section 4.13 (Alternative Payment Models) of the DMCM Model Contract, DHHS will issue a Medicaid APM Strategy that may include supporting guidance, worksheets, and templates that will build upon the parameters set forth in the DMCM Model Contract. In the interim, DHHS is interested in understanding how the Respondent would propose to implement APMs that meet DHHS's goals and requirements as described broadly and as specifically related to APMs, as described in Section 4.14 (Alternative Payment Models) of the MCM Model Contract.

Section 13 Point Allocation	
Question(s)	**Points**
47-48	25
49	15
Total	40

Q47. Submit to DHHS an initial proposed APM Implementation Plan, including all required components described within the DMCM Model Contract. DHHS recognizes that this Implementation Plan may require further iteration based upon DHHS's issuance of the DHHS Medicaid APM Strategy. The APM Implementation Plan shall clearly describe what steps the DMCO will take at Program Start, and within the first 6, 12, and 18 months of implementation of the DMCM Agreement, including:

1) The Respondent's approach for making accommodations for small Providers;

2) How the Respondent will align its approach with the HCP-LAN APM framework and existing APM models, including those that are aligned to "Other Payer Advanced Alternative Payment Models" under the requirements of the Quality Payment Program as set forth by MACRA;

3) How the Respondent will adhere to all APM model transparency and reporting requirements outlined within the DMCM Model Contract;

4) The Respondent's approach, consistent with the requirements outlined in the DMCM Model Contract, to Provider engagement and data sharing.

Q48. For all proposed APM models included in the Respondent's APM Implementation Plan, clearly articulate how the Respondent will be transparent both in contracting with Providers and with DHHS on all elements of the Respondent's APM offerings, including:

1) How Member attribution will be determined, the frequency at which attribution will be re-assessed, and how Providers will be proactively made aware of the Members attributed to the Provider on a timely and actionable basis;

2) The methodology for developing quality targets and the frequency at which participating Providers will receive that information;

3) ;

4) By providing a sample reporting template that will be shared with Provider APM participants to support concurrent utilization management as well as retrospective information for the development of an performance under the DO's proposed APM models;

5) The method and frequency of reporting to Provider participants in APMs; and

6) In the interest of support DHHS's development of a standard APM reporting template, a proposal for how the DO recommends it should submit quarterly APM results in a Standard Template.

Q49. To the extent the Respondent has prior experience implementing APMs (or similarly defined payment models) among its provider network(s), the Respondent should include a table indicating all of its current APM arrangements across all lines of business and states. The table should include:

1) Name of the APM program;

2) Line(s) of business to which the program applies (e.g., Medicaid, Medicare Advantage, etc.);

3) State(s) in which the program applies;

4) Whether the arrangement was required by the state and, if so, under what state program;

5) Description of the APM program;

6) The method of attributing members;

7) The total member lives and member months attributed to the APM;

8) The applicable HCP-LAN APM category/sub-category (e.g., Category 2B) in which the arrangement best fits;

9) Provider types governed under the arrangement, and the percentage of APM expenditures each provider type represents;

10) Service types governed under the arrangement;

11) Quality requirements included as part of the arrangement;

12) Percent of total Medicaid spending governed under the arrangement for the relevant line of business in the most recent 12-month measurement period;

13) Percent of total Medicaid spending projected to be governed under the relevant line of business in the next 12-month measurement period;

14) Total payments (or negative payments) made to provider participants based on their performance in the APM; and

15) Any other metrics or information determined by the Respondent to be important to the success or failure of the APM.

14. Provider Payments

Section 14 Point Allocation	
Question(s)	**Points**
50-51	10
Total	10

Q50. Describe the Respondent's process for meeting the prompt payment requirements described within the MCM Model Contract.

Q51. Describe the Respondent's process for paying claims based on the effective date of the Current Procedural Terminology (CPT) code.

15. Claims Quality Assurance and Reporting

Section 15 Point Allocation	
Question(s)	**Points**
52-56, 58	6
57	4
Total	10

Q52. Please submit a flow chart and narrative of the Encounter Data submission process the Respondent will employ in NH, including but not limited to, how accuracy, timeliness, and completeness of data will be ensured.

Q53. Completeness of Encounter Data submissions requires that key fields are populated accurately for every encounter submission; describe the quality control processes that will ensure key fields are accurately populated when encounters are submitted.

Q54. Indicate what quality control procedures the Respondent will use to ensure documentation and coding of encounters are consistent throughout all records and data sources and across Providers and Provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and its methodology for eliminating duplicate data.

Q55. Indicate any feedback mechanisms that the Respondent will use to improve Encounter Data accuracy, timeliness, and completeness, and the tools and methodologies that will be used to determine compliance with Encounter Data submission requirements.

Q56. Include documentation of the Respondent's most recent three (3) years of Encounter Data submission compliance ratings for at least one Medicaid managed care contract arrangement. The documentation should be an assessment completed either by DHHS (the Medicaid Agency or the Agency with which the Respondent was contracted) or the External Quality Review Organization.

Q57. Describe how the Respondent will work with Providers – particularly subcapitated Providers, Subcontractors, and Non-Participating Providers – to ensure the accuracy, timeliness, and completeness of Encounter Data.

Q58. Provide a table listing all instances in the last five (5) years and for all Medicaid managed care contracts in which the Respondent was: (1) delayed in submitting Encounter Data; (2) unable to submit Encounter Data; and/or (3) otherwise out of compliance with a state's requirement to provide Encounter Data.

16. Oversight and Accountability

Section 16 Point Allocation	
Question(s)	**Points**
59	3
60-61,64-65	6
62-63, 66	19
67-68	2
Total	30

Q59. Please indicate the number of times, over the past five (5) years, that punitive action has been taken against the Respondent (i.e. required to submit CAPs, monetary or non- monetary penalties imposed, Capitation Payments withheld, etc.) by state Medicaid agencies. Describe the reason each action was taken and what the Respondent did to improve performance in response to the action.

Q60. Provide a copy of the following:

1) Policies and procedures demonstrating compliance with 42 CFR Section 438.608.

2) Policies and procedures regarding recovery, reporting and tracking of Overpayments.

3) Policies and procedures on collection and maintenance of information on ownership and control to demonstrate compliance with Sections 3.1.14.3 (Ownership and Control Disclosures) and 5.3.7 (Access to Records, On-Site Inspections, and Periodic Audits) of the MCM Model Contract.

4) Policies and procedures demonstrating compliance with False Claims Act, and other federal and state laws described in Section 1902(a)(68) of the Social Security Act.

Q61. Describe how background and exclusion screenings, and the frequency of which, are conducted on:

1) Board Members

2) Employees

3) Vendors

4) Contractors

5) Subcontractors

Q62. Describe data analytic algorithms that will be used by the Respondent for purposes of fraud detection.

Q63. Describe the Respondent's specific controls to cost avoid and detect and prevent potential FWA including, without limitation:

1) A list of automated pre-payment claims edits, including National Correct Coding Initiative edits;

2) A list of automated post-payment claims edits;

3) A list of audits of post-processing review of claims planned;

4) A list of reports on Participating Providers and Non-Participating Providers profiling used to aid program and payment integrity reviews;

5) The methods DO will use to identify high-risk claims and DO's definition of "high-risk claims";

6) Visit verification procedures and practices, including sample sizes and targeted Provider types or locations;

7) A list of surveillance and/or Utilization Management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

8) A method to ensure that services represented as delivered by Participating Providers were received by Members;

9) A list of references in Provider and Member material identifying fraud and abuse reporting hotline number;

10) Work plans for conducting both announced and unannounced site visits and field audits of Providers determined to be at high risk to ensure services are rendered and billed correctly;

11) The process for putting a Provider on and taking a Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate; and

12) The ability to suspend Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity.

Q64. Describe the resources for FWA including the organization and reporting structure, and the number of Full Time Equivalents (FTEs).

Q65. Provide the Respondent's policy regarding how credible allegations of fraud or abuse shall be referred to DHHS Program Integrity.

Q66. Describe the Respondent's experience with Provider recovery collection. Provide any empirical evidence of the Respondent's collection success rate.

Q67. Describe any training programs that the Respondent's organization uses to train employees to recognize and report patterns of fraud and abuse.

Q68. Describe how the Respondent engages Members in preventing fraud and abuse.

17. Third Party Liability / Coordination of Benefits

Section 17 Point Allocation	
Question(s)	**Points**
69 & 72	10
70-71	10
73	10
74	10
75	10
Total	50

Q69. Describe how the Respondent will:
1) Query data sources to identify potential sources of TPL; and
2) Identify and maintain other potential TPL when adjudicating Members' claims.

Q70. Provide the number of FTE(s) that will be dedicated to TPL and COB identification and recovery and to whom they will report.

Q71. Describe how the Respondent will maximize the identification and recovery of TPL.

Q72. Describe the Respondent's method, process, and system edits for:
1) Capturing third-party resource and payment information from the Respondent's claims system; and
2) Cost avoiding through COB optimization.

Q73. Describe the process the Respondent uses for retrospective post-payment recoveries of health-related insurance, whether done by the DO or a Subcontractor.

Q74. Describe the Respondent's TPL collection rate broken down by category when a third-party payer is identified for each of the organizations provided in response to Question 2 (under Managed Care Experience and References) of this RFP.

Q75. Describe the Respondent's process for sharing TPL and COB information with DHHS; and describe the Respondent's subrogation case tracking and process for cost avoiding and recovering funds related to subrogation cases and other TPL coverage.