APPENDIX E

Appendix E

Work Statement Questionnaire

For all sections, applicants should align their responses with the requirements of the draft CHC agreement.

Applicants should incorporate the evaluation considerations listed in Section II-4.A of the RFA, Soundness of Approach, into their responses. This includes, but is not limited to, providing data that demonstrates how the Applicant's existing process and past performance has improved quality, access, and value for the CHC Program or a similar program.

A. PLANNED APPROACH. (Maximum 40 pages for section).

1. Describe in detail how you will develop your provider network (physical health and LTSS services) and set up operations capable of supporting the participant population and meeting requirements of the agreement no later than three months prior to the anticipated implementation dates for each zone.

a. Describe your approach for meeting all requirements and include:

a. A detailed description of your project management methodology. The methodology should address, at a minimum the following:

a) Issue identification, assessment, alternatives, and resolution; and

b) Resource allocation and deployment.

b. Describe your approach for status reporting and other regular communications with the Department, including a description of your proposed method for providing adequate and timely reporting of data to Department personnel.

2. Provide a work plan for implementation. At a minimum, the work plan should include:

a. A description of all activities necessary to obtain required contracts or agreements for your provider network, including how you will build a culturally appropriate and diverse network to meet the unique needs of the CHC population. Also include how you would ensure that the providers' offices are building and equipment accessible for the population.

b. An itemization of activities that you will undertake during the period between notification of selection to proceed to Readiness Review and the anticipated implementation date for each zone. Include established deadlines and timeframes for the activities.

B. PARTICIPANT SERVICE COORDINATION AND CARE MANAGEMENT. (Maximum 50 pages for section).

1. Describe your philosophy and approach for employing the following through service coordination and care management, including, but not limited to, how the approaches

were/will be measured and reported to DHS as per the CHC Agreement, and the results of your past experience, if any:

a. Person-centered team planning approaches including, but not limited to, the assessment process and the person-centered plan development process;

b. Person-Centered Planning including, but not limited to, how to develop comprehensive emergency and individualized back-up plans for instances where there might be service interruption;

c. Approach to whole person care;

d. Self-direction, including processes to educate and train participants on this service delivery model;

e. Incentives for health and wellness; and

f. Approaches for sustaining family and personal connections and community involvement.

2. Describe how your organization will work with the CHC LTSS population to meet their varying and unique needs.

3. Describe your experience working with the Non-LTSS Dual Eligible population, including past strategies your organization has utilized to maintain the participant's health and wellness. Describe the strategies your organization proposes use to maintain the participants' health and wellness for this Project.

4. Describe your past experience and proposed approach for screening CHC participants to determine service needs. This includes, but is not limited to, conducting assessments and reassessments, and using existing or developing new tools and systems to support these processes.

5. Describe your process for providing that individuals with a brain injury receive an appropriate assessment by a professional with the appropriate training and experience in brain injury. The assessor should be able to recognize and assess the impact of cognitive and behavioral impairments on functioning.

6. Describe your proposed approach and planned strategies for identifying and serving people with the following conditions including but not limited to:

a. Neurocognitive impairments;

b. Intellectual and Developmental Disability ("IDD");

c. Ventilator/Tracheostomy Dependent; and

d. Neuromuscular disorders.

7. Given the growing population who are eligible for and enrolling in CHC, what is your organization's strategy to address the population growth so that you can meet all of their needs?

8. Describe your past experience and your planned approach to participant service coordination, including care management, assessment, and responsiveness. At a minimum include the following:

    a. Education to the participant, family, and others on how the assessment process works and how it relates to the final Person-Center Service Plan (PCSP) and their services;

    b. Ensuring the participant's ability to have access (24-hour access and response) to the Service Coordination team;

    c. Communication plan to ensure Service Coordinators are accurately communicating and explaining any type of service change(s) in a timely manner that ensures the participant's full understanding of the changes; and

    d. Education and assistance to the participant in the grievance and fair hearing process.

9. Describe your approach to verifying your LTSS Service Coordinators are culturally competent and have the tools and expertise to support the independent living goals of the CHC population and receive at least 40 hours of training annually in the following at minimum:

    a. Conducting a person-centered assessment;

    b. Developing and modifying a participant's PCSP including communication to the participant;

    c. CHC Waiver Services;

    d. Participant Direction;

    e. Improving communication skills;

    f. Acquiring conflict resolution skills;

    g. Completing documentation;

    h. Understanding the disabilities of participants served;

    i. Understanding cultural diversity among the populations;

    j. Medicare benefits and Medicare coordination;

    k. Community Resources;

    l. Assistive Technology (Resources); and

m. Working with provider associations who specialize in complex care needs.

10. Describe your approach to the recruitment and retention of your LTSS Service Coordination workforce. Explain how the Service Coordinator will interact with other departments within your organization including, but not limited to, how their input from the assessment process will be incorporated in developing the overall person-centered service plan.

11. Describe your experience with and your planned approach to using a Person-Centered planning team for service planning. This description should include, but is not limited to, how your organization coordinates the person-centered planning process between the various departments within your organization.

12. Describe your process for including providers in the person-centered planning team and your approach to communicating the information in the PCSP to the direct service provider.

13. Describe your process for service planning that is person centered, is conducted in a cognitively accessible manner and has a participant's goals and preferences at the center of the process. Include the communication process with the participant and how he or she will be supported in the most integrated setting with preference and priority for supporting the participant in their own home.

14. Describe any evidence-based practices, including, but not limited to, tools, that your organization uses for person-centered planning.

15. Describe your organization's past experience and your proposed plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC participants.

16. Describe the techniques, policies, procedures, or initiatives you have in place and those that will be used for CHC to:

a. Provide participants with adequate in-home services to divert them from entering or returning to acute or long-term care facilities.

b. Use community resources, such as community health workers, and natural supports to improve wellness, education on health options, and to improve community involvement.

c. Effectively and appropriately control avoidable nursing facility, hospital, and emergency department admissions and other high-cost services and to increase the use of health promotion, primary care, and Home and Community Based Services ("HCBS").

d. Describe how you will determine the level of full time equivalent licensed and non-licensed telephonic and community-based personnel that will be involved in these

activities. Include the plan of care monitoring, and the documentation and sharing of background checks, licensures, and necessary trainings credentials.

17. Describe the strategies, techniques, policies, procedures, or initiatives you have in place or what you will use to effectively and appropriately manage the Transition of Care ("TOC") for participants being discharged from inpatient care and how these techniques control hospital and nursing facility admissions and readmissions.

18. Describe how you encourage provider usage and exchange of interoperable health information and electronic service plans, and how you will develop and implement innovations to use these records to promote better coordination and overall health.

19. Describe your approach to utilization management for CHC, including:

a. Lines of accountability for utilization policies and procedures and for individual medical necessity determinations.

b. Processes for determining medically necessary services, including but not limited to the use of professionals with the appropriate expertise and experience and integration of an understanding of the impact of cognition, behavior, and brain injury issues on functioning for LTSS and for approving and authorizing service plans.

c. Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated.

d. Process and resources to develop utilization review criteria, especially the monitoring of authorized services compared to delivered services.

e. Review and authorization of Person-Centered Service Plans.

f. Prior authorization processes for participants requiring services from non-participating providers or for participants who require expedited prior authorization review and determination.

g. Processes to provide for the consistent application of criteria by clinical reviewers.

h. Processes for distinguishing between initial authorizations and reauthorizations.

i. Processes for the assessment of medical necessity.

j. Training on utilization process for service coordinators and ensuring transparency for participants.

20. Describe your plan's approach to prioritizing HCBS and providing the most integrated setting for service delivery.

21. Describe your past experience and proposed approach to participant Services and call center management. Describe your existing and proposed performance measures and

how you will determine staffing levels. Experience should include an approach to easily access a participant's service coordinator including 24-hour access to a member of the service coordination team. Transitions from participant hotline to service coordination service team.

22. Describe how your Participant Advisory Committee ("PAC") are embedded in evaluating and enhancing your operations and policies.

23. Specify how you will coordinate your service coordination and your care management programs to establish a person-centered approach is taken for chronic conditions and disease management activities for all participant populations, including the use of any technology to stratify and track participants most in need of disease management. Also describe the disease and population health management programs your organization has in place now, indicating what disease categories they target and how you have or will integrate into LTSS programs. Describe how you have determined their success, including, but not limited to, how participants are educated about the programs and how to maintain or improve their health and wellness. Identify and describe the programs that will be used if awarded.

24. Describe your approach for training staff and providers in the submission and review of Letters of Medical Necessity for physical health services and person-centered service plans. Describe the steps to minimize the number of denials for services that are issued, especially for LTSS, due to a lack of all information being submitted at the initial request.

25. Describe your policies and processes that will be used by staff and service coordinators to communicate with participants with disabilities, limited English proficiency, or low literacy levels. Please include how you will ensure that underrepresented and marginalized populations are identified and engaged.

26. Describe your approach to assisting participants through the MA financial redetermination process. In addition, describe what the service coordinator's role is in these activities as applicable.

27. Describe your approach for authorizing LTSS services in accordance with the requirements of 1915(c) Waivers. Your response should address authorization timeliness communications of authorizations and strategies for reducing administrative burden for providers or other health and home care professionals.

28. Describe the procedures, education, and processes you will have in place for coordination of care for a smooth transition of CHC participants who transfer between care settings. Specifically, describe the support efforts you will use to transition participants from:

a. Acute care, hospital, behavioral health rehabilitation or any other provider owned or controlled settings to community-based settings;

b. Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") services to CHC;

c. LIFE providers;

d. OPTIONS program;

e. Other waiver programs;

f. Act 150;

g. Department of Corrections; and

h. Other community locations.

29. Describe how your person-centered service planning process will support informal caregivers.

30. Describe your existing and proposed policies and procedures when care is provided by out-of-network providers and the methods you will use to verify or evaluate the quality of care delivered, including, but not limited to, any potential barriers and the resolution process.

31. Describe your existing and proposed process for establishing caseloads for service coordinators and what caseloads you will target for the CHC population including:

a. Describe how your CHC-MCO will approach the service coordination ratio (to be no less than 1 service coordinator to 50 HCBS participants and 1 service coordinator to 200 nursing facility participants).

b. Describe how you plan to minimize service coordinator turnover.

c. Describe how you will ensure a participant is notified of a change in service coordinator, including how choice of new service coordinator will be discussed with the participant.

d. Describe how you will address mixed caseloads of HCBS and Nursing Facility caseloads, and how the service coordinator is appropriately trained on both.

e. Describe how you would manage service coordination in urban, suburban, and rural settings.

32. Describe how you will use various additional data sources and coordinate care across various payers, the data and information that will be necessary for you to coordinate care as required for the CHC program, and how you intend to obtain this necessary data.

33. Describe your approach to meeting the physical health needs of participants who are medically complex or homebound.

C. PARTICIPANT DIRECTION. (Maximum 20 pages for section).

1. Describe your knowledge of the participant-directed options available in the CHC Waiver program and strategies you will employ to promote the growth of these models including examples of how you have successfully grown participant directed options in Pennsylvania and other markets, if applicable.

2. Describe your existing and proposed approach to educating participants about the benefits of participation direction and why the option to self-direct services through the participant-directed model of service delivery provides the most flexibility and consumer control for service delivery. Describe how you ensure participants have primary authority for making decisions about these services. Include your approach to making distinctions between participant-directed options and agency model.

3. Describe the supports and training you currently have or will have available to participants who may be interested in using the participant-directed model of service delivery. Describe how you would support the different participant-directed models: Agency with Choice (upon federal approval approval), Financial Management Services/consumer direction, and Service My Way.

4. Describe how you will support the successful use of participant-directed options for participants who select this model. Include how you will help support participant strengthen their recruitment, hiring, managing, directing, supervising and training of direct care workers to preserve and strengthen the participant's retention of direct care workers. Describe how you ensure quality of service delivery and promote use of EVV.

5. Describe how you will support the consumer directed workforce including examples of innovative approaches to address increasing awareness of the consumer-directed program, access to supplies, training opportunities, and other resources.

D. SERVICE INNOVATION. (Maximum 25 pages for section).

1. What is your SDOH risk assessment process and what risk mitigation strategies would you employ to address those risks including but not limited to:

   a. Housing;

   b. Employment;

   c. Food insecurity;

   d. Literacy;

   e. Transportation;

   f. Workforce;

   g. Access to health services;

   h. Environmental conditions;

i. Income; and

j. Relationships.

2. Describe any current or planned community programs and initiatives your organization has been involved in aimed at addressing affordable, accessible, and adaptable housing. Also include how you would assist participants with general home maintenance and repairs.

3. Describe any current or planned initiatives related to employment services aimed to increase access to competitive integrated employment opportunities for participants.

4. Describe any current or planned initiatives to address food insecurity for participants.

5. Describe any current or planned initiatives to address literacy for participants.

6. Identify barriers and describe your approach to providing transportation to meet the social and health needs of participants. Include how you plan to approach cross county situations and any examples of any successes with the stated approach.

7. Describe your current or planned initiatives to develop and support the direct service workforce.

8. Describe your current or planned initiative to expand the use of technology among LTSS providers.

9. Describe how you will ensure participants will have appropriate affordable and timely health services.

10. Describe how you would address hazardous or unsafe environmental conditions.

11. Describe how you propose to offer participants in lieu of services and rationale for offering such services including improved outcomes for participants receiving those services.

E. SERVICE INTEGRATION AND CARE COORDINATION. (Maximum 25 pages for section).

1. Describe the approaches you will use to coordinate MA and Medicare services, including primary, acute, and LTSS, including how you will do this for participants in aligned or unaligned D-SNPs, other Medicare Advantage Products, and Medicare fee-for-service.

2. Describe the procedures and processes you will have in place for coordination of care with Medicare providers and how you will provide access to Medicare services. Include how providers will have secure access to all data needed to coordinate care.

3. Describe how your plan will create, maintain and continuously improve quality and services provided for participants served in nursing facilities including any innovations

for monitoring participant's needs, changes in condition, and opportunities to rapidly react to infection outbreaks.

4. Describe your plan to create, maintain, and continuously improve collaboration with HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs). Include a description of methods you will use to exchange information relevant to providing coordination of services, including behavioral health utilization data provided by the Department.

5. Describe your plan to create, maintain, and continuously improve collaboration across all participants' providers including those that are not part of the CHC-MCO network. Include a description of methods you will use to exchange information relevant to providing services coordination and care management amongst participants, providers, and service coordinators.

6. Describe how your plan will ensure that eligible participants have Part D coverage and how will you coordinate with each participant's Medicare Part D coverage.

7. Provide your model of care and an explanation of how it aligns with your D-SNP model of care. Please attach your D-SNP model of care.

8. Describe the approaches you will use to coordinate with veterans' health services or veterans' health coverages for participants.

9. Describe your past experience in and proposed approach to coordinating services with your D-SNP and other D-SNPs.

10. Describe your past experience in and approach to coordination among physical health, behavioral health, and LTSS.

11. Describe any current or planned approaches to those participants with Behavioral Health needs.

12. Describe any value-added benefits and your rationale for offering such services including improved outcomes for members receiving the services, and your experience offering such enhanced benefits to similar populations.

F. QUALITY IMPROVEMENT AND PERFORMANCE MEASURES. (Maximum 25 pages for section).

1. Describe your strategy for achieving quality performance and outcomes for the delivery of services.

2. Describe all physical health and HCBS quality and performance measures that you currently track and your performance in these measures. Specifically detail any LTSS quality measures and your performance. Address how you measure utilization, timeliness of service delivery, and rebalancing (HCBS vs Nursing Facility). Describe, out of all the

measures you collect, which three are the most meaningful in measuring HCBS quality and performance and why.

3. Describe your strategy for controlling chronic conditions such as high cholesterol, high blood pressure, and diabetes.

4. Describe your strategy to address progressive conditions such as Parkinson's, Multiple Sclerosis, Dementia Alzheimer's type, Vascular Dementia, and education to participant's and families with diseases on coordination of care and resources.

5. Describe your strategy for addressing and measuring the needs of participants with progressive, debilitating diseases such as but not limited to dementia and other neurocognitive diseases in community settings.

6. Describe your strategy for addressing the needs of participants with acquired brain injuries in community settings, including but not limited to identifying appropriate quality metrics for brain injury specific services.

7. Describe your strategy for approaching service delivery in rural, suburban, and urban areas of a zone, including LTSS, preventive, and acute care.

8. Describe your plans to measure preventive care services and their impact on improvement in disease management.

9. Describe your current programs or plans to develop programs for dental care services, especially in more rural, suburban, and urban areas.

10. Provide an example of an HCBS or similar type quality improvement initiative in which you have participated, including the measures used, your results, key success factors and barriers to success. Describe how this experience will be used for CHC.

11. Describe how you will engage your PAC in quality improvement.

12. Describe the role your service coordinators will play in HCBS quality assurance and improvement. Describe the relationship between care management of chronic conditions and disease management and service coordination as it relates to quality assurance.

13. Describe your strategy for meeting the current Value-Based Purchasing ("VBP") requirements in Section VII.E.16 of the Draft Agreement (Appendix B of the RFA) and how you intend to expand VBP arrangements beyond these requirements in the future.

14. Provide the three most recent completed years of HEDIS® rates for the measures set forth below and indicate the line of business. Applicants currently participating in CHC must provide the three most recent completed years of HEDIS®* rates for the HEDIS® performance measures for the CHC Program for the zones in which they currently participate. Applicants that do not currently participate in Pennsylvania's CHC Program must provide rates for HEDIS® from a Medicaid line of business from another state. If the Applicant has a Medicaid product in more than one state, you must choose ONE state

that is most similar to Pennsylvania. Provide an explanation of the basis for your determination that the state is most similar to Pennsylvania. (Limit to one page)

a. Controlling High Blood Pressure;

b. Comprehensive Diabetes Care: HbA1c Poorly Controlled;

c. Comprehensive Diabetes Care: LDL Control <100;

d. Breast Cancer Screening (Ages 42-69 years);

e. Cervical Cancer Screening (Ages 24 to 64 years);

f. Cholesterol Management for patients with Cardiovascular Conditions: LDL-C Controlled<100; and

g. Emergency Department Utilization.

*The Healthcare Effectiveness and Data Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance.

G. DIVERSITY, HEALTH EQUITY, AND INCLUSION. (Maximum 10 pages for section).

1. Describe how your organization will address health disparities. Describe your approach to perinatal care and other health related disparities.

2. Describe the management techniques, policies, procedures, and initiatives you have implemented and will implement to promote health care equity (i.e., reductions in disparity in treatment and outcomes among disparate races and ethnic groups). Please provide the results and any lessons learned about these efforts. Describe the strategy to be used for CHC.

3. Describe your leadership plans or efforts to measure and prioritize diversity, equity, and inclusion. Please describe your proposed plan for the CHC program.

H. PROGRAM INTEGRITY. (Maximum 20 pages for section).

1. Describe the controls you will implement and enforce around program integrity.

2. Describe the controls you will implement around third-party liability.

3. Describe the types of fraud, waste, and abuse detection methods you will use to detect and prevent potential provider and participant fraud, waste, and abuse.

4. Describe how you monitor and how you will monitor the performance of your subcontractors for compliance with all responsibilities outlined in the draft Agreement. Provide sample reports showing actions taken to improve performance and achieve positive results. Describe any sanctions or penalties that apply if a subcontractor fails to perform. Provide as an attachment sample performance monitoring reports.

5. Describe your method and process for capturing third-party resource and payment information from your claims system for use in reporting cost-avoided dollars and provider-reported savings to the Department. Explain how you will use such information. Describe the process you use for retrospective post-payment recoveries of health-related insurance as well as your process for adjudicating a claim involving an accident or estate recovery.

I. DRUG SERVICES. (Page limits identified for each subsection below). Responses should be based on the requirements in **Exhibit D** of the draft Community HealthChoices Agreement.

1. How will the CHC-MCO ensure payment is made only for rebate eligible outpatient covered drugs? (Limit to 2 pages).

2. Describe how the CHC-MCO will implement, maintain, and support the Pennsylvania Medical Assistance Statewide Preferred Drug List (PDL). (Limit to 3 pages).

3. Describe how the CHC-MCO will ensure that coverage of all drugs covered under the CHC-MCO's Medical Benefit will comply with requirements in Exhibit D. (Limit to 3 pages).

4. Describe how the CHC-MCO will comply with the following Pharmacy Provider Network Requirements (Limit to 4 pages):

   a. How the CHC-MCO will comply with the requirement to contract on an equal basis with the willing and qualified pharmacies under 62 P.S. § 449.

   b. How the CHC-MCO ensures that the payment rate, including ingredient cost and professional dispensing fee, paid to all network pharmacies reflects the pharmacist's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary.

5. Describe how the CHC-MCO will comply with the Pharmacy Benefit Manager ("PBM") section in Exhibit D. Descriptions should include, but are not limited to, the following (Limit to 10 pages):

   a. The relationship between the CHC-MCO and the PBM;

   b. The payment arrangement between the CHC-MCO and the PBM;

   c. How the CHC-MCO will comply with transparent pricing; and

   d. How the CHC-MCO will comply with PBM provider pricing disputes and Second Level PBM Provider Pricing Dispute Resolutions.

6. What subcontracts will the CHC-MCO utilize in the coverage and management of covered drugs? Describe how the Offeror will monitor subcontractors for compliance with the requirements in Exhibit D. (Limit to 5 pages).

7. Please describe how the CHC-MCO will address drug supply shortages. (Limit to 1 page).

J. MANAGEMENT INFORMATION SYSTEMS. (Maximum 20 pages for section).

1. Provide a general systems description, including:

   a. A systems diagram that describes each component of the management information system and all other systems that interface with or support it;

   b. How each component will support the major functional areas of CHC (In-Plan Services; Coordination of Care; Participant Services; Complaint, Incident Management, Grievance and Fair Hearings; Pharmacy; Provider Network; Provider Services; Service Access; Quality Management/Utilization Management; Claims Payment and Processing; and Encounter Data Reporting);

   c. Describe the capacity and security of your systems and their ability to handle the CHC population; and

   d. System interactions with State systems including the Pennsylvania Individual Assessment System or others as determined by the Department.

2. Describe the Management Information System and other tools that service coordinators will use to coordinate Medicare and MA Services.

3. Describe any modifications or updates to your Management Information System ("MIS") that will be necessary to meet the requirements of the draft Agreement, and your plan for their completion, including timeframes.

4. Describe the current capacity of your MIS/claims processing. Explain your process to readily expand your MIS/claims processing should the capacity of either be exceeded.

5. Explain how you will require your subcontractors to meet the same MIS requirements for which you are responsible, including any incentives or assessments that will be utilized.

6. Describe the capability to access a database of service information to create ad-hoc reports for both MCO management and the Department. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability you will have to use large amounts of data to create standard hard-coded and ad-hoc reports.

7. Describe the capability and amount of access you will have to your subcontractor's information to create ad hoc reports or retrieve standard hard-coded reports.

8. Describe how you will verify that providers and subcontractors submit timely, accurate, complete, and required encounter data elements for subsequent transmission to the Department, including the frequency of verification.

9. Describe how you will manage the non-submission of encounter data by a provider or subcontractor, including any corrective actions or assessments that may be imposed.

10. Describe in detail your existing and proposed process for utilizing the Department's daily and monthly 834 membership files to manage your participant enrollments. If the membership information in your system does not match the membership information on the daily and monthly 834 files, how do you resolve the discrepancy?

11. Explain, in detail, your existing and proposed process for reconciling that the correct payments were made for your plan's recipients using the Department's 820 Premium Payment File. What is your process for resolving or correcting errors should you find discrepancies?

12. Explain in detail your existing and proposed process for providing participant enrollment information to each of your subcontractors (dental, vision, pharmacy, etc.). Include the subcontractor's name, their purpose, and how often membership data is submitted.

13. Explain your existing and proposed process for maintaining your provider file with sufficient information on each provider to support provider payment and also meet the Department's reporting and encounter data requirements. Include how you will cross-reference your internal provider ID number with the PROMIS*e*™ provider ID and service location and the provider's NPI number with taxonomy and zip code.

14. Explain your existing and proposed processes for verifying that providers are enrolled in MA and have a valid PROMIS*e*™ provider ID number/service location and NPI/taxonomy/zip code. Include how you will require and monitor your subcontractors to have their providers enrolled in MA program and have a valid PROMISe™ Provider ID number/service location and NPI/taxonomy/zip code.

15. Describe how you will comply with claims timeliness standards and how you will ensure providers are paid timely and correctly. Specifically, note how these will be measured and what dates will be used.

16. Describe your approach for achieving accurate and timely submissions of complete HIPAA compliant 837 and NCPDPencounter data consistent with required formats.

17. Describe how you will comply with the data completeness monitoring program requirements, including the submission of a plan.

18. What is your plan to communicate outcome measures to Network and Out-of- Network Providers?

19. Describe your current system for providing access to all network providers to enrollment, service coordinator contact, and service plan information.

20. Describe your existing and proposed approach to addressing significant data breaches and detail any examples of past data breaches within your organization and how you addressed them.

21. Describe the process you currently have and what you will use for clinical data sharing from MCO to MCO when members move from a service area or elect to change their MCO.

K. PROVIDER NETWORK COMPOSITION AND NETWORK MANAGEMENT.

(Maximum 25 pages for section).

1. Explain your plan to create a provider network that meets the network and access requirements. Specifically, include:

a. The method you plan to use on an ongoing basis to assess, meet, and maintain network standards for all provider types.

b. Describe the process you will work with prospective providers in a zone in which you feel that you have an adequate network.

c. Describe your experience with VBP agreements and how you will help elevate the readiness for LTSS providers to engage in VBPs/Alternative Payment Mechanisms and higher levels of VBPs.

d. Describe your process for continuous improvement in your network.

e. Describe how you will include in your network any qualified HCBS provider, nursing facility, and LTSS providers that are enrolled MA providers at the time of implementation.

f. Describe how you will achieve appointment access standards, including when participants cannot access care within your provider network and must go to an Out-of- Network provider.

g. Describe how you will provide access to necessary covered services when participants cannot access services within your provider network.

h. Describe how you will provide choice of medical, LTSS, and service coordination network providers for participants.

i. Describe how you will collect and address the language, communication, and participant-specific needs, including how you will build a diverse and culturally appropriate network to meet the unique needs of the population.

j. Describe how you will educate your provider network about participants' communication needs and coordinate interpreter services.

k. Describe how you will meet accessibility standards within your provider network for participants who require reasonable accommodations. Specifically address physical accessibility and cognitive accessibility. Also address the accessibility of appointments in a reasonable timeframe.

2. Describe the processes you have used and will use to correct deficiencies and make improvements in provider network access and accessibility. This includes, but is not limited to:

    a. Describe provider incentives or programs used to encourage greater access throughout the network.

    b. Describe how provider network adequacy and access monitoring is integrated in your overall quality improvement programs.

    c. Describe the plan to recruit providers, and correct deficiencies should they occur.

    d. Describe the methods your provider network support staff will utilize to engage and educate providers.

    e. Explain the circumstances that will result in providers not being approved to participate in your network.

3. Describe how your organization will establish a dental provider network to meet or exceed compliance levels for dental needs of participants through the use of incentives or other provider attraction techniques. Provide recent examples of dental network improvements made by your organization. Specifically describe how your network will meet the dental needs of participants in nursing facilities or require accommodations to access dental services.

4. Describe your organization's oversight process for subcontractors that manage provider networks, such as dental, vision, and other benefits managers, including:

    a. Describe actions taken in the past as well as those that will be taken to correct identified network deficiencies or problems with accurate and timely provider reimbursement.

    b. Describe incentives, quality improvement processes, or assessments pursued to increase network access and accessibility of subcontractor provider networks as well as those that will be used if selected for award.

5. Explain your plan to manage contracted nursing facility health providers, non-skilled home care providers, and other LTSS providers to meet participants' needs for access to HCBS and innovative housing options.

6. Describe risk adjustment strategies, provider incentives, or both you will employ in Primary Care Physician ("PCP") contracting to provide participants with complex medical needs with adequate access to primary care services. Describe how you measure the adequacy of access and what programs you will have in place to measure the quality outcomes of services.

7. Describe how you monitor and evaluate PCPs and other provider compliance with availability and scheduling requirements outlined in the Agreement. Describe your plan to achieve and maintain PCP-to-Participant ratio requirements.

8. Describe how you provide participants with access to medical care for needs that arise after hours and for urgent, non-emergency situations. Describe how you monitor providers to ensure that follow-up is done with the participant and the participant's PCP to facilitate transfer of information from the after-hours provider. Describe any incentive programs you have in place to improve access to care for providers who provide extended or after-hours care.

9. Describe your policies and procedures for responding to network provider terminations or loss of a large-scale provider group or health system. Please develop the response taking the following areas into consideration:

    a. System utilized for identification and notification of participants affected by the provider loss;

    b. The automated systems and membership support utilized in assisting participants with provider transitions;

    c. Systems and policies utilized for continuity of care for participants; and

    d. Outcomes experienced in coverage of the membership with existing network resources following the terminations.

10. Explain how you will provide participants with access to in-home services if scheduled services become unavailable.

11. Describe how you will educate the provider network about particular services and administrative issues associated with Full Dual Eligibles. What are the major issues that require education?

12. Describe how you will oversee the administration of Financial Management Services for participants.

13. Describe how you will approach nursing home transition ("NHT"), including but not limited to how you will approach NHT for populations with barriers to housing, complex care needs, behavioral health needs.

14. Describe by major service category the size and market share of any provider and provider organization that is related or affiliated with your MCO.

L. Case Scenarios. (Maximum 25 pages for section). Unless otherwise indicated, applicants should address all aligned Dual-eligible, unaligned Dual-eligible, and Medicaid-only participants.

1. A participant has called your participant Services hotline and wants to connect with their Service Coordinator to request assistance with her services. She has received a promotion at work and is worried about how it will impact her eligibility, her services, and her ability to get to the new office location in a neighboring county. She is 45 years old, has quadriplegia, and uses a power chair that hasn't been functioning properly.

2. You have received notification that a new participant transitioning will be transitioning from EPSDT services into Community HealthChoices and has selected your health plan. He is a twenty-year-old male who utilizes a ventilator and plans to attend college that begins in three months. The participant has selected the Consumer Directed model.

3. A participant who is a dual eligible Nursing Facility Ineligible was admitted to a Skilled Nursing Facility for follow-up care after a left leg amputation as a result of uncontrolled diabetes, hypertension, and chronic obstructive pulmonary disease. They experienced housing instability prior to the admission and are now homeless. How would you support the participant and the provider with ensuring a safe discharge?

4. A participant has been a nursing home resident for five years and has expressed interest in returning to the community. Their family has concerns that the participant would return to past substance use and would not be safe in the community. The participant is a wheelchair user who has IDD, cerebral palsy, high blood pressure, and depression.

5. A 43-year-old participant with a traumatic brain injury informed you that his aging parents are no longer willing to have him reside with him in their home and needs help. In speaking with the parents, you learn that they are overwhelmed with his behaviors and the participant has become violent at times, has angry outbursts, and has made poor decisions, which recently included allowing a stranger into their home. They feel like he cannot be left alone, and they are no longer able to support him especially given the escalating tensions between the participant and the parents when the parents try to have him agree to their house rules.

6. An individual who lives in a rural area has reported issues with getting to their dialysis appointments consistently and are afraid they will lose their dialysis spot. The participant is unable to be compliant with care gaps for dental care, annual wellness visits, blood pressure checks related to inability to secure consistent transportation to appointments. The participant also mentioned that they have been feeling sad lately from missing several family events due to not being able to get there.

7. An 85-year-old participant with progressing Alzheimer's Dementia lives with their 88-year-old spouse and has recently reported difficulty in managing their spouse due to wandering and sundowning. They have been reluctant to accept home care support given their religious, cultural or other personal beliefs.