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Guide to the Request for Proposal (RFP) for the Medicaid Standard Plan

The RFP for Prepaid Health Plans (PHPs) and Provider-Led Entities (PLEs) is actually a set of five documents. Each are inter-related to the other. Here's a breakdown of a few key subjects you will find covered in each document:

Index to RFP Documents

General RFP Document includes:

- specific timeline for implementation;
- general contract requirements for the PHP/PLE;
- definitions and acronyms.

Addendum 1, Scope of Services includes PHP requirements such as:

- **Administration and Management:**
  National Accreditation, PHP will achieve national accreditation by NCQA for all services including long-term services and supports by the end of Contract Year 3 for the Standard Plan; requirement that submission of a draft Implementation Plan occurs fourteen days after the contract is awarded;
- **Members:**
  Specific provisions that cover what a Medicaid beneficiary can expect to receive from a PHP or PLE in areas such as eligibility and enrollment, Medicaid beneficiary (or "Member") rights, appeals and grievances, education, covered physical health services (listed on pages 43-79) and covered behavioral health services (listed on pages 79-80); and, Medicaid beneficiary co-pays set at $2-$3 (listed on page 90).
  Member Engagement is a separate category and includes the requirement for a Long Term Services and Supports Advisory Committee. The RFP states, "*The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the PHP or their representatives and include: a) Members accessing LTSS; b) Representatives of LTSS Members; c) LTSS providers; and d) PHP staff involved in the authorization of LTSS and/or care management of LTSS users.* "
- **Benefits and Care Management:**
  In-depth explanations of services including, utilization management expectations and required behavioral health screening tools to be used; allowance for Value-Added Services, which are items and services that are not plan benefits and for which the PHP/PLE does not receive compensation in their capitation rate; transition of care requirements when a Medicaid beneficiary is moving from fee-for-service or from another PHP; and, care management.
  Behavioral Health and I/DD Assessment Tools to be used by the PHP: EPSDT criteria for evaluation and assessment of children; American Society for Addiction Medicine (ASAM) criteria for all individuals age 6 + for substance use services; LOCUS criteria

for adult mental health services; CALOCUS criteria for child (ages 6-17) mental health services; Early Childhood Services Intensity Instrument (ECSII) criteria and Children and Adolescents Needs and Strengths (CANS) criteria for the aged 0-5 population; Supports Intensity Scale (SIS) for individuals with I/DD over age 5.

- **Providers:**
  Reviews multiple requirements of PHPs to ensure that their network complies with amount and types of services; includes provision of a second opinion in network when requested by Medicaid beneficiary, assistance with out-of-network providers and sufficient access to women's health specialists; Network Access Plans to be completed and submitted to NC DHHS 30 days after the contract awards (expected in February 2019); PHPs are required to contract with all State psychiatric facilities and ADATCs; PHP will establish a Provider Network Participation Committee to make quality determinations; Medicaid beneficiaries will be notified when a provider he/she has seen within the last year is terminated or no longer in the network and the PHP will make best effort to notify affected beneficiaries 15 days after NC DHHS notifies the PHP to terminate the provider contract; provides more explanation about payment to each category of provider; expectations of NC DHHS to use quality metrics as accountability and tracking through specified reporting by the PHPs and withholds that will begin in Contract Year 3; Value-Based Payments/Alternative Payment Models (covered in-depth below); requires partnerships that include a Local Community Collaboration Strategy be submitted to NC DHHS within 90 days from the Contract Award and integration with local DSS, ombudsman and enrollment broker.
- **Program Operations:**
  Requires a Behavioral Health Crisis Line, 24/7/365, staff with licensed BH professionals, calls must be answered in house with no busy signal and not forwarded, PHP must have capacity to connect to crisis response systems and patch to 911.
  The Nurse Line must be integrated with care management, i.e. the Nurse Line must follow up with the PHP care management within 48-hours after a Medicaid beneficiary/member has called the Nurse Line.
- **Claims and Encounters:**
  Prompt payment [to providers] standards are set, similar to what is currently in place for LME/MCO and provider contracts. Pharmacy prompt payment standards are slightly different.
  Providers have 180 days to submit claims. PHPs will pay an 18% interest rate when they do not pay the provider within the prompt payment requirements as well as a 1% penalty (with certain restrictions).
- **Medical Loss Ratio (MLR):** The MLR is set at 88%. The MLR indicates the proportion of the total Per Member Per Month capitation that MUST be used towards services. In this case, 88% of the PMPM capitation must be spent directly on services and the remaining 12% may be used to cover the indirect/administrative services.
- **Program Integrity:** The PHP is responsible for having a structure in place to identify fraud, abuse or waste in the Medicaid program by providers within the network of each PHP. That includes capacity to monitor and audit providers and report to NC DHHS.

- **Data Exchange Model:** Page 215 includes a diagram that shows the expected flow of data, including from the provider, PHP, Advanced Medical Home, Enrollment Broker and NC DHHS. That data includes eligibility files and information, encounter (claims and other data) submissions, Medicaid beneficiary choice of AMH, and enrolled providers.

Addendum 2, Attachments A – N includes:

- Contract Performance, including the "liquidated damage" or financial penalties for not meeting contractual service level compliance, for PHPs/PLEs. PHPs/PLEs will have an initial 18-month grace period before they are held to these penalties;
- Minimum certifications and credentials of PHP/PLE staff and roles and positions, including positions for which the employee must reside in North Carolina;
- Clinical coverage list or list of services that are a part of the Contract Performance, including BH *in lieu of* services that will be covered—Behavioral Health Urgent Care, Outpatient Plus, In Home Therapy Services for Children with MH/SUD Diagnosis, Child First Outpatient, BH Crisis Risk Assessment and Intervention (BH-CAI), Rapid Care Services;
- Quality Metrics (measured outcomes) for the PHP/PLE to achieve and PHP reporting requirements;
- Network Adequacy Standards, including behavioral health;
- Provider Appeal Criteria because PHPs must offer an appeal process for providers on contract issues;
- PHP reporting requirements;
- Medicaid Policies including: Enrollment (page 89); Care Management for At-Risk Children ages 0-5 as identified by Local Health Departments (page 108); Behavioral Health Service Definition (page 116).

Addendum 3, Attachment O includes all of the RFP areas and guidelines for response that the PHP/PLE should complete.

Addendum 4, Draft Rate Book includes the Contract Year 1 of the Standard Plan draft capitation rates developed by population and by region. The rates range from $136.70 for a child aged 1-20 per month in Region 6 to $1529.02 for an individual who is Aged, Blind or Disabled in Region 3 per month. This addendum also includes the data fields used to determine the capitation rates and many, many pages of data from SFY16 and SFY17 that DHHS and their contractor used to determine the rates.