MEMORANDUM

To: **Drew Snyder, Executive Director**
From: **Coordinated Care Procurement Evaluation Committee**
Date: **July 26, 2022**
Re: **Coordinated Care Procurement Overview and Evaluation Report**
RFQ: 20211210
RFX: 3150003991

MISSISSIPPI DIVISION OF MEDICAID

Procurement Overview

The Division of Medicaid (DOM) is seeking to establish contracts for the delivery of managed care services for its Mississippi Coordinated Access Program (MississippiCAN) and Mississippi Children's Health Insurance Program (CHIP). Per the Request for Qualifications, DOM will contract with no fewer than two (2) and no more than three (3) contractors for the delivery of these services.[1] The initial contract term will be four (4) years, with an option for two one-year extension periods thereafter.

DOM submitted a petition for relief to the Public Procurement Review Board (PPRB) for approval to conduct this procurement using an alternative procurement method. DOM received approval from PPRB on June 2, 2021, to solicit the services listed above as a Request for Qualifications (RFQ).[2,3] This procurement was run in accordance with all state rules and regulations, including but not limited to the Office of Personal Service Contract Review Rules and Regulations as promulgated by the PPRB.[4]

Evaluation Committee

The evaluation committee for the solicitation signed confidentiality agreements and conflict of interest agreements and was comprised of the following staff:

1. Samantha Atkinson, Deputy Administrator, Accountability and Compliance
2. Dr. Catherine Brett, Quality Director, Mississippi UM/QIO[5]

[1] *See* https://medicaid.ms.gov/coordinated-care-procurement/, DOM Coordinated Care RFQ – RFQ No. 20211210, Section 1.2, Procurement Overview.
[2] *See* Public Procurement Review Board (PPRB) Telephonic Meeting Minutes, Wednesday, June 2, 2021, page 20: https://www.dfa.ms.gov/media/pimjkofz/6-pprb-agenda-minutes-6-2-21.pdf. *See also* Appendix F, Petition for Relief.
[3] The Request for Qualifications and all related materials, including all amendments, are available on DOM's dedicated CCO Procurement Website: https://medicaid.ms.gov/coordinated-care-procurement/. A detailed explanation of the terms, payment, conditions, scope of services sought through this procurement, and other relevant matters are explained in the RFQ and in Appendix A to the RFQ, entitled "CCO Contract, both of which are incorporated via reference.
[4] The Office of Personal Service Contract Review Rules and Regulations can be found at https://www.dfa.ms.gov/media/9413/pprb-opscr-rules-and-regulations-efficetive-01182020.pdf.
[5] Dr. Catherine Brett is employed by Alliant Health Solutions, DOM's Utilization Management/Quality Improvement Organization vendor. She also serves as the Quality Director for DOM. Her resume is attached to this document in Appendix C.

3. Jennifer Grant, Benefit Program Manager, Medical Services
4. Keith Heartsill, Healthcare Financial Consultant[6]
5. Sharon Jones, Director, Office of Managed Care
6. Evelyn Sampson, Information Technology Project Manager Team Lead[7]
7. Jennifer Wentworth, Deputy Administrator for Finance

Procurement Process Prior to Qualification Evaluation

DOM issued its RFQ on December 10, 2021, with a Letter of Intent and Questions deadline of January 7, 2022. Letters of Intent were received from five Potential Offerors:[8]

1. Amerigroup Mississippi, Inc. (Amerigroup)
2. Magnolia Health Plan, Inc. (Magnolia)
3. Mississippi True d/b/a True Care (True Care)
4. Molina Healthcare of Mississippi, Inc. (Molina)
5. UnitedHealthcare of Mississippi, Inc (UHC)

Amerigroup, Magnolia, True Care, and Molina also submitted Questions by the January 7th deadline. UHC confirmed that they had no questions to submit by the January 7th deadline.

DOM issued initial responses to Questions submitted by Potential Offerors by the January 7 deadline on February 7, 2022.[9] Requests were received to clarify certain elements of DOM's answers, and due to the complex nature of this procurement, DOM allowed questions clarifying the first answer set to be submitted by February 14, 2022.[10] Amerigroup, Magnolia, True Care, and Molina also submitted Questions by the February 14 deadline. UHC confirmed that they had no questions to submit by the February 14 deadline. Clarifying answers were issued by DOM on February 16, 2022.[11]

Additionally, a Pre-Qualification Conference was held on January 14, 2022.[12] Potential Offerors were told to submit any questions specific to the conference in writing no later than January 19, 2022. DOM issued answers to submitted questions on January 21, 2022.[13]

As stated in the RFQ, the Qualification submission deadline was March 4, 2022, 2:00 p.m., via electronic upload to a dedicated SharePoint site. All Potential Offerors that submitted a Letter of Intent also submitted their RFQ by the stated deadline. The Qualifications were opened at 2:30 p.m. the same day, as stated in the RFQ, a Register of Qualifications was created, [14] and procurement review began immediately.

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[6] Keith Heartsill is a contractor for DOM. His resume is attached to this document in Appendix C.
[7] Evelyn Sampson had a more limited role in Technical Evaluation, focusing on technological aspects of proposals. She participated fully in the Management Evaluation.
[8] All Offerors that submitted a Letter of Intent later submitted offers. However, for clarity of timeline, they are each referred to as "Potential Offerors" for any actions prior to the submission deadline.
[9] *See* https://medicaid.ms.gov/coordinated-care-procurement/, Amendments 4-8, Amendment 11
[10] *See* https://medicaid.ms.gov/coordinated-care-procurement/, Amendment 9.
[11] *See* https://medicaid.ms.gov/coordinated-care-procurement/, Amendment 12.
[12] *See* https://medicaid.ms.gov/coordinated-care-procurement/, Amendment 10 for the Transcript of the Pre-Qualification Conference.
[13] *See* https://medicaid.ms.gov/coordinated-care-procurement/, Amendment 2.
[14] The Register of Qualifications is included at Appendix A.

Evaluation of Qualifications

All Qualifications were evaluated using the process described in Section 3: Qualification Overview and Process of the RFQ. A standard evaluation form was utilized by the Evaluation Committee to ensure consistency in evaluation criteria. Evaluation forms for each Offeror are included as an Appendix B to this Report.

Stage 1: Evaluation of Offeror's Responses to the RFQ

In this Stage, each Qualification was reviewed to determine whether it was responsive, complete, and compliant with the instructions to Offerors in the RFQ. Qualifications were additionally reviewed to find, and redact if possible and as needed, any potentially identifying information that would violate PPRB Rules or Statute.[15,16] As stated in the RFQ, DOM reserved the right to waive minor variances or reject any or all qualifications.[17]All Qualifications were largely in compliance as submitted and could be cured to be able to make it to the next phase of evaluation.[18]

Stage 2: Evaluation of Qualification

The Evaluation Committee reviewed each Offeror's qualification to determine if the Offeror sufficiently addressed all of the RFQ requirements and that each Offeror developed a specific approach to meeting each requirement.

Stage 2.1: Evaluation Rounds and Consensus Scoring

The Evaluation Committee evaluated the Technical (Unmarked) and Management (Marked) Factors in two distinct Rounds. During Round 1, the Evaluation Committee reviewed the Technical Factors, and the Management Factors were reviewed in Round Two. This ensured that Technical Factors were reviewed "blind," meaning the Evaluation Committee was not informed of the identity of the Offeror/author of each qualification's Technical Factors. During Round 2, the Evaluation Committee was informed of the identity of the Offeror/author of each qualification's Management Factors.

The Evaluation Committee used a Consensus Scoring method to award points in both of the Evaluation Rounds. The Evaluation Committee evaluated the Technical (Unmarked) and Management (Marked) Factors in two distinct Consensus Scoring sessions, with sessions occurring after each Round's evaluation period was complete.

Evaluation Round 1: Technical Factors – Unmarked/Blind – 450 Points Available

During Round 1, the Evaluation Committee reviewed the Technical Factors. Technical Qualifications were given to the Evaluation Committee on April 4, 2022.[19] Each member independently evaluated

[15] Review was conducted by Margaret Middleton, Attorney III for the Division of Medicaid; Drew Weiskopf, Senior Manager for Cambria Solutions; Phyllis Williams, Senior Consultant for Cambria Solutions; Jeanette Crawford, Procurement Officer for the Division of Medicaid; and Kate Holland, Procurement Officer for the Division of Medicaid.

[16] For more information about identifying information, *see* PPRB Rule 3-203.12, Receipt, Opening, and Registration of Proposals and Qualifications; *see also* Miss. Code Ann. § 31-7-417. DOM also applied its rules for Identifying Information as defined in DOM Coordinated Care RFQ – RFQ No. 20211210, Section 1.2.3.3.2, Definition of Identifying Information, located at https://medicaid.ms.gov/coordinated-care-procurement/.

[17] *See* https://medicaid.ms.gov/coordinated-care-procurement/,DOM Coordinated Care RFQ – RFQ No. 20211210, Section 3.2.2, Stage 2: Evaluation of Qualifications.

[18] An overview of curative measures is included in Appendix D, Memorandum of Redactions and Cures.

[19] Because of her more focused, limited role, Evelyn Sampson did not receive access to Technical Qualifications until April 18, 2022.

each Offeror's Technical Factors qualification. At the end of the Round 1 Evaluation Period, the Evaluation Committee convened to assign consensus scores to each Offeror's Technical Factors qualification, arriving at both consensus scores and consensus comments to support those scores. Consensus Scoring for Technical Qualifications was conducted from May 9, 2022 – May 19, 2022.[20] Independent facilitators were used to conduct the consensus scoring.[21] After the Round 1 Consensus Scoring was completed, the Technical Factor qualification scores were locked and could not be changed by the Evaluation Committee.

Evaluation Round 2: Management Factors – Marked/Informed Scoring – 200 Points Available

During Round 2, the Evaluation Committee reviewed the Management Factors. Management Qualifications were given to the Evaluation Committee on June 15, 2022. Each member independently evaluated each Offeror's Management Factors qualification. At the end of the Round 2 Evaluation Period, the Evaluation Committee convened to assign consensus scores to each Offeror's Management Factors qualification, arriving at both consensus scores and consensus comments to support those scores. Consensus Scoring for Management Qualifications was conducted from July 11, 2022 – July 15, 2022. Independent facilitators were used to conduct the consensus scoring.[22] After the Round 2 Consensus Scoring was completed, the Management Factor qualification scores were locked and could not be changed by the Evaluation Committee.

To ensure fairness, prior to receiving the Management Qualifications of each Offeror, each member of the Evaluation Committee signed an attestation that they would not access information about Technical Qualifications, including but not limited to the Qualifications themselves and the consensus scores and comments.[23] The Evaluation Committee also was not given the identity of Technical Qualification Offerors until the Management Consensus Scoring was concluded and scores were locked.

Stage 3: Selection

After the Evaluation Committee completed the evaluation of the qualifications, this summary report including all scores and comments for all Offerors, is now submitted to the Executive Director of the Division. As stated in the Section 3.2.3 of the RFQ, the Executive Director will make the final decision regarding the winning qualifications. The Office of Procurement, its designees, and the Evaluation Committee will provide any further information as needed to the Executive Director in making the final selection.

[20] Readers will note that Evaluation Committee Members signed Technical Qualification Consensus Scoring documents May 20, 2022 – May 26, 2022. No scores or comments were altered after May 19, 2022; the dates of signing are staggered merely due to Evaluation Committee Member availability/access to Docusign.
[21] Technical Consensus Scoring was conducted by Margaret Middleton, Attorney III for the Division of Medicaid; Drew Weiskopf, Senior Manager for Cambria Solutions; and Phyllis Williams, Senior Consultant for Cambria Solutions.
[22] Management Consensus Scoring was conducted by Margaret Middleton, Attorney III for the Division of Medicaid; Drew Weiskopf, Senior Manager for Cambria Solutions; and Phyllis Williams, Senior Consultant for Cambria Solutions.
[23] *See* Appendix E.

Evaluation Committee Rankings and Scores

Following the completion of the evaluation process, scores and rankings based on the overall score of Qualifications are as follows:

Rank Overall	Offeror Name	Overall Score	Technical Score	Technical Rank	Management Score	Management Rank	Price[24]
1	Mississippi True d/b/a TrueCare	**821**	348	1	123	3 - Tie	350
2	Magnolia Health Plan, Inc.	**792**	332	2	110	5	350
3	Molina Healthcare of Mississippi, Inc.	**726**	250	3	126	2	350
4	UnitedHealthcare of Mississippi, Inc.	**715**	242	4	123	3 - Tie	350
5	Amerigroup Mississippi, Inc.	**710**	229	5	131	1	350

Recommendation

The Evaluation Committee recommends that the Executive Director award contracts based on the Overall Rankings stated above. It is at the Executive Director's discretion as to whether two (2) or three (3) contracts are awarded. The Evaluation Committee, utilizing the process described herein, ranked True Care, Magnolia, and Molina respectively as the top three Offerors based on Technical and Management factors.

Should there be two contracts awarded, the top two ranked Offerors are True Care and Magnolia, each of which delivered especially strong Technical Qualifications, including innovative and ambitious approaches to delivery of services. Should a third contract be awarded, the third-ranked Offeror, Molina, presented a very sound overall proposal, ranking third among Technical Qualifications and second among Management Qualifications. More in-depth reasoning for the Evaluation Committee's scores and rankings is included in Appendix B: Consensus Scores and Comments.

The recommendation of the Evaluation Committee is: X **Approved** _ **Rejected**

Comments: DOM intends to award three (3) contracts to the top three ranked Offerors: Mississippi True d/b/a TrueCare, Magnolia Health Plan, Inc., and Molina Healthcare of Mississippi, Inc.

Drew Snyder

Drew L. Snyder
Executive Director
Mississippi Division of Medicaid

Date: 8/9/2022 | 4:44:07 PM CDT

[24] State statute requires that Price be included as a scored factor in any RFQ, with a value of at least 35% of the score. *See* Miss. Code Ann. § 31-7-413(2)(a); *see also* PPRB Rule 3-204.01.3. Evaluation Factors. Because the subject contract is paid through a capitated payment, Offerors did not submit any information regarding Price with their qualifications. Every qualification was awarded 350 points for Price, without exception, leaving 650 points for competitive evaluation scoring.

Appendix A: Register of Qualifications

REGISTER OF PROPOSALS

Mississippi Division of Medicaid Coordinated Care

RFQ # 20211210
RFx # 3150003991

A – Molina Healthcare of Mississippi, Inc.
B – UnitedHealthcare of Mississippi, Inc.
C – Mississippi True d/b/a TrueCare
D – Amerigroup Mississippi, Inc.
E – Magnolia Health Plan, Inc.

Appendix B: Consensus Scores and Comments

Consensus Scoring: Amerigroup Mississippi, Inc. (Amerigroup)

Technical Factors Evaluation
Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991

Offeror D

EVALUATION ROUND 1: TECHNICAL FACTORS – BLIND SCORING CONSENSUS

Summary of Point Distribution by Section

RFQ Question Set Topic	Related Contract Section(s)	Possible Points	Score
Methodology/Work Statement			
Executive Summary		Pass/Fail	Pass
Member Services and Benefits	Covered Services and Benefits	50	28
Provider Services and Network	Provider Services	50	26
Care Management	Care Management	50	26
Quality Management	Quality Management	50	27
Utilization Management	Quality Management, Throughout the Draft Contract	50	25
Information Technology	Throughout the Draft Contract	20	8
Subcontractual Relationships and Delegation	Subcontractual Relationships and Delegation	20	7
Financial and Data Reporting	Throughout the Draft Contract	15	6
Program Integrity	Fraud, Waste, and Abuse. Throughout the Draft Contract	15	9
Subrogation and Third-Party Liability	Third-Party Liability	10	5
Eligibility, Enrollment, and Disenrollment	Eligibility, Enrollment, and Disenrollment	10	7
		340	**174**
Innovation and Commitment			
Value-Based Purchasing	Quality Management	20	11
Patient-Centered Medical Homes	Provider Services	10	6
Social Determinants of Health	Throughout the Draft Contract	20	11
Value-Adds		10	4
Performance Improvement Projects	Quality Management	10	2
Health Literacy Campaigns	Quality Management	10	4
Telehealth	Covered Services and Benefits	10	7
Use of Technology	Member Services, throughout the Draft Contract	10	5
Potential Partnerships	Throughout the Draft Contract	10	5
		110	**55**
Total Points		**450**	**229**

Offeror D

Rating Guide

Rating for Applicable Section	50 Possible Points	20 Possible Points	15 Possible Points	10 Possible Points
Excellent Value (100%) Response exceeds expectations for many or all aspects of requirements and at least satisfies all aspects of requirements.	50	20	15	10
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	16	12	8
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	12	9	6
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	8	6	4
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	4	3	2
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0

Technical Factors Evaluation
Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991

Offeror D

Executive Summary (Pass/Fail)
Response is limited to 10 pages

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Did the Executive Summary include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of: • Proposed work plan; • Staff organizational structure; • Key personnel; and, • A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements? 2. Did the Executive Summary demonstrate the Offeror's understanding of the Division's vision for the Contract?	

Offeror D

Methodology Work Questionnaire (MWQ)

Directions from the RFQ:

Please respond to the questions. These statements and questions relate directly to the Major Program Elements described in Section 1.3.7 of this RFQ and related requirements set forth in Appendix A, Draft Contract. Please respond completely but succinctly. When specified, page limits indicate the maximum length of a response. Offerors are encouraged to respond in fewer pages if that is possible. Indicate "not applicable" to any item that is not relevant to the Offeror's qualification. Required documentation for specific answers will not be included as part of page limits and should be included in the body of the response, not as an attachment, unless otherwise indicated.

Unless specified, questions apply to both MississippiCAN and CHIP. If the Offeror's processes and procedures will differ by program for any requested item, make that distinction in the answer.

The Offeror should not construe a Contract section's listing as "related," to denote that the section listed is the only section in which the Question Set Topic is mentioned. The Offeror is responsible to reading and understanding all parts of the Appendix A, Draft Contract, and using that information to be responsive to the Question Sets.

The Offeror is reminded of the prohibition against including identifying information in any of answers. Where model documents are requested, the Offeror must remove all identifying information. Failure to comply with this rule may be basis for disqualification.

Unless specified, questions apply to both MississippiCAN and CHIP. If the processes for both are the same, note that. If the processes are different, make the distinction.

As noted above, the total number of points available for responses to this subsection is 340 points. Points available per element of this subsection are included in the element's title.

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available

Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each.

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Delivery of Covered Services 1. Children a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following: i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach	Notes: • Use of dedicated EPSDT Coordinator • Enhanced EPSDT provider education using EPSDT toolkit • Focus on improving adolescent immunization rates • Personalized methods for EPSDT reminders • Will waive co-pay for CHIP population • Integrated desktop for call center staff to easily locate member information • Maintains phone recordings for 10 years • Innovative use of teledentistry • Dedicated Member Advisory Committee • Offered adequate Wound Care program • Twice weekly messaging to members • Transition plan for postpartum women • Response lacks specificity and actionable language • No funding allocation to providers to offset the cost of group pregnancy class start up and maintenance • Lacks actionable detail and steps for identified issues in Member Services, more emphasis on monitoring and collaboration than action

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, Immunizations, Well-Child visits, and any other services described in the CHIP State Health Plan. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children? 2. Behavioral Health Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
health/substance use disorder, including compliance with the SUPPORT Act. c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services? 3. Perinatal and Neonatal a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services. b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services. c. Describe any innovative methods that Offeror will use to augment its approach. d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services? 4. Chronic Conditions a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally. c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally. d. Describe any innovative methods that Offeror will use to augment its approach.	

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions? 5. Foster Children a. Describe the Offeror's experience and/or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs. b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population. c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in its efforts to accurately identify and subsequently serve the medical needs of foster children and youth. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children? 6. Dental Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services? 7. Vision Services	

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services. b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding vision services? 8. Additional Items a. State whether the Offeror will required any cost-sharing or copayments from MississippiCAN and/or CHIP Members. i. If yes, please describe what these cost-sharing/copayment requirements will be. b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP). c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section. d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services. **B. Member Services Call Center** 1. Describe the Offeror's Member services call center operations, including: a. Confirming that the location of the proposed operations will be within the State of Mississippi (provide a yes or no answer; do not include address); b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure	

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
standards are met (the Division retains the right to approve all call center standards); c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available; d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled; e. Training program for call center employees including cultural competency and Care Management; f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime; g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week; 2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities. **C. Member Handbook** 1. Describe how the Offeror's Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services. 2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System? **D. Website and Mobile Application** 1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application. 2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any).	

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Member Education and Communication 1. Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use. 2. Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use. 3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including: a. An overview of the program, including accountabilities and proposed activities; b. The Offeror's rationale for selecting areas of focus; c. How the Offeror will ensure that materials are at a third (3rd) grade reading level; d. The language alternatives available to non-English speakers/readers; and, e. How Members who are visually and/or hearing impaired will be accommodated. 4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities. 5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe. 6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract. 7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104.	

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available. 8. Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services. 9. Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division. **F. Member Satisfaction** 1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties. **G. Member Appeals** 1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract; b. Process for expedited review; c. Involvement of Members and their families in the Grievance and Appeal process; d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements;	

Offeror D

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How Grievances are addressed prior to the filing of a Member appeal; and f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.	

[END OF SECTION]

Offeror D

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)

Response Limit: 45 pages, plus model provider contracts

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Provider Network 1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include: a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts; b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network; c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities; d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy; e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PMHCs' compliance with availability and scheduling appointment requirements and ensuring Members have	Notes: • Provider network strategy includes actionable plans for provider recruitment and provider retention. • Will establish target ratios of Members-to-Providers by Provider type to account for expected utilization of services. • Will use NCQA Member-to-Provider ratios assuring appropriate access for services. • Does not guarantee that any willing provider will meet network quality standards • Lacks specificity throughout this RFQ section • Provider payments subsection simply stated that requirements would be followed but did not provide any specificity • Sample contracts allow for binding arbitration, which is not authorized by DOM

Offeror D

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and, f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network. g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy. 2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities. 3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. 4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete. 5. Submit templates of the Offeror's standard Provider contracts. 6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including: a. System used to identify and notify Members affected by Provider loss;	

Offeror D

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
b. Automated systems and membership supports used to assist affected Members with Provider transitions; c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition; and, d. Approach to cover membership needs with existing network resources following terminations. 7. Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care. 8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to: a. Issue IRS 1099 forms, b. Meet all federal and Division reporting requirements, and c. Cross-reference to state and federal identification numbers to identify and report excluded Providers. **B. Provider Services Call Center** 1. Describe the Offeror's Provider services call center operations including: a. Hours of operation; b. Describe how the Offeror will ensure call center employees will have cultural competency; c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards);	

Offeror D

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
d. Training program for call center employees including local and statewide cultural competency; and, e. A description of any plans to use electronic communication to respond to Provider inquiries. 2. Describe how the Offeror will assess the quality and efficiency of the Call Center. **C. Provider Education and Communication** 1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system. 2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a Member for behavioral health/substance use disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems. 3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections. 4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics. 5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.	

Offeror D

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties. 7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services. 8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances: a. Perinatal; b. Behavioral Health; c. Substance Use Disorder; d. Chronic Conditions; and e. Foster Children. **D. Collaboration with Providers** 1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity. 2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care. 3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members.	

Offeror D

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Provider Payment 1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis. 2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Offeror's claims processing system. 3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s). **F. Provider Grievances and Appeals** 1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract; b. Process for elevating Provider Grievances; and, c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.	

[END OF SECTION]

Offeror D

MWQ 4.2.2.3: Care Management (50 Total Possible Points)

Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages.

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Care Management Proposal 1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response: a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach; b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities; c. How the Offeror will ensure that Care Management is a tool to address health equity concerns; d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and, e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high). **B. Stratification and Assignment** 1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking	Notes: • Unique "Locate and Engage" Program to locate members in a community and establish a connection • Details unique partnership with ambulance companies for a limited program to treat Members in-place when hospitals are not local • Lack of comprehensive, statewide programs • Lacks overall detail and actionable steps • Services for all risk levels are weak • Inadequate management of low-risk populations with limited resources provided and extended re-evaluation timelines • Inadequate detail of performance measures; lacks specific action steps to achieve success • No mention of coordination with statewide HIEs • Insufficient details of an overall communication strategy to DOM

Offeror D

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
answers, and how answers will be used for stratification of Members based on acuity levels and Care Management. 2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management. 3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment with the Offeror in order to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment. 4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools. 5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA. **C. Care Management Services** 1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
notify Members and/or Providers when follow-up is due. Address the following issues in the response: a. Facilitation and monitoring of Member compliance with treatment plans; b. Partnerships of community-based partnerships and other state agencies; and c. Coordination with other Providers. 2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in identifying and gaining access to community resources that may provide services not covered. 3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response: a. The Offeror's role and the PCP's/PCMH's role in this process; b. Examples of information that the Offeror will provide to Providers; c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and, d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation. e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties. **D. Transition of Care** 1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process. 2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including: a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services; b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff; c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and, d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and network pharmacist to assure continuation of needed therapy. 3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation.	

Offeror D

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Staff 1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following: a. Education and training required for Care Managers; b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers; c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases; d. And overview of the Offeror's continuing education and training plan for its Care Managers; and e. Expected wages to be paid to Care Managers (hourly/salary and what amounts). **F. Hypotheticals** 1. Describe the Offeror's approach to providing Care Management in the following scenarios: a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months; b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable; c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health	

Offeror D

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
needs was admitted last night to a local inpatient facility after presenting with an asthma attack; d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week; and, e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a Member.	

[END OF SECTION]

Offeror D

MWQ 4.2.2.4: Quality Management (50 Total Possible Points)

Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to 10 pages.

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Quality Management Program 1. Describe the Offeror's proposed quality management program, including: a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable; b. The program's lines of accountability; c. Process for selecting areas of focus; d. Process for using evidence-based practices; e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy; f. Use of data to design, implement and evaluate the effectiveness of the program; g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and h. How the Offeror will address health access and equity in its quality management program 2. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages). **B. Clinical Guidelines and Compliance** 1. Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines.	Notes: • Detailed list of reporting tools • Proactive plan to share data with DOM • Lacks overall actionable steps to drive quality outcomes • Lacks specificity on how they would use advanced data & analytics • Lack of substance on how to address SDOH strategies • Appears to be more directed at quality assurance than at quality management • QM Committee structure does not appear to be balanced or well thought out • Insufficient details of an overall communication strategy to DOM

Offeror D

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 3. Describe the Offeror's proposed process for compliance with the SUPPORT Act. 4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 5. Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered. 6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers. 7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for precluding payment to Providers and reporting to the Division via encounter data in accordance with 42 C.F.R. § 438.3. 8. Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions. **C. Quality Measurement** 1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract. a. Describe the type of build necessary to create these types of reports.	

Offeror D

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidences efficacy of programs.	

[END OF SECTION]

Offeror D

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)

Response Limit: 30 pages

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to utilization management, including: a. A description of the utilization management program; b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures; 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 used to develop utilization review criteria; e. Expected Prior Authorization clinical criteria by program area; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates; g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization; h. The Offeror's approach to reducing the number of Prior Authorizations required; i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and	Notes: • Plans to connect VBP to UM review • Use of clinical services committees will ensure clinical guidelines are not more restrictive than DOM's • Will partner with DOM and other CCOs to standardize PA requirements, notifications, and documentation • Lacks specificity to support a good understanding of UM, such as confusing the use of EQRO for UM activities (page 305) • Lack of focus on overall UM processes

Offeror D

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
j. Processes to ensure consistent application of criteria by individual clinical reviewers. **B. Methods** 1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy. 2. Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program. 3. Describe how the Offeror will identify and address trends in over- and under-utilization. 4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members. 5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.	

[END OF SECTION]

Offeror D

MQW 4.2.2.6: Information Technology (20 Total Possible Points)

Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages.

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Claims Processing 1. Describe the Offeror's claims processing system including: a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program. 2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion. 3. Describe the Offeror's claims processing operations including: a. The claims processing systems that will support this program; b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program; c. The Offeror's process for dealing with discovered compliance issues through an expedited process; d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an example of how the Offeror has addressed these deficiencies or variances.	Notes: • Claims processing operations includes TPL identification and integration • Comprehensive member dashboard made available to providers and Community-Based Organizations through secure web portal • Innovative and technological methods made available for members and providers • HIPAA-compliant virtual assistant to help members manage care from their homes. • Offers monthly education and training to providers regarding claims submission and payment process for only 1st 12 months of contract • Figure 4.2.2.6.A.1-1: o Does not show the inclusion of sub-contractor encounters o Fails to effectively define the use of vendors vs. subcontractors o Lacks clarity in explanations of the subcontracting claims process o The chart and the written explanation are incongruent • Offeror states they will resolve provider claims disputes within sixty days, and the DOM Draft Contract requires thirty days resolution for appeals

Offeror D

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
B. Technological Systems 1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System. 2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies. 3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate. 4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies. **C. Innovation** 1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members. 2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network. 3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division. **D. Continuity of Operations** 1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including a. Employee training; b. Essential business functions and responsible key employees;	

Offeror D

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; d. Communication with staff and suppliers when normal systems are unavailable; e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components; f. Security and privacy requirements; and g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.	

[END OF SECTION]

Offeror D

MQW 4.2.2.7: Subcontractual Relationships and Delegation (20 Total Possible Points)

Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Services to be Subcontracted 1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor. 2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor. **B. Subcontractor Oversight** 1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will: a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor; b. Ensure receipt and reconciliation of all required data including encounter data; c. Ensure appropriate utilization of health care services; d. Ensure delivery of administrative and health care services meets all standards required by this RFQ; e. Ensure adherence to required Grievance policies and procedures; and, f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how	Notes: • Provides detailed explanation of the encounter reconciliation process • The Offeror's chart (4.2.2.7.A.1-1) does not efficiently and accurately identify which subcontractors are affiliated with the offeror • Lacks sufficient details regarding subcontractor program • Failed to describe how the Offeror will perform the duties outlined in this RFQ section

Offeror D

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
the Offeror has addressed a deficiency or contractual variance with a Subcontractor. g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division. h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.	

[END OF SECTION]

Offeror D

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)

Response Limit: 20 pages

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Financial Reporting 1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c). 2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized. **B. Data Reporting** 1. Encounter Data a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan. 2. Health Information System Data a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes,	Notes: • Calculation of MLR includes cost not typically allowed in the MLR calculation • Encounter data flow diagram is difficult to understand and incongruent with expectations for 4.2.2.6.A.1-1 • The encounter data completion percentage for financial data does not meet the contract requirement of 99%.

Offeror D

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
integrates, validates, and reports data including but not limited to the following areas: i. Utilization, ii. Claims, Grievances and Appeals, iii. Disenrollment (for other than loss of Medicaid eligibility), iv. Member Characteristics, v. Provider Characteristics, vi. Care Management Utilization, vii. Clinical Data, and viii. Population Health.	

[END OF SECTION]

Offeror D

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)

Response Limit: 20 Pages

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Fraud, Waste, and Abuse 1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including: a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable; b. Process for acting upon suspected cases of fraud, waste and abuse; c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers; d. Process for interacting with the Division, including the Office of Program Integrity; and, e. Other components of the Offeror's fraud, waste, and abuse program. **B. Claim Denials** 1. Describe the Offeror's proposed Denials Review and Reporting program, including: a. A description of the Offeror's Denials Management program; b. A summary/listing of the Offeror's denials criteria/protocol; c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria; d. The Offeror's reconsideration process as it relates to claims denials; and	Notes: • Provided significant commitment to a dedicated fraud team to be located in MS • The proposal commits the local fraud team to leverage the National SIU group and dedicate two SIU investigators to Mississippi as well. • Strong statement of commitment to full transparency and communication with MS regulators • Proposal described a commitment to a Rapid Resolution Team, which will assist providers in more efficient and effective claims denial resolutions • Charts on pages 379 and 380 provide a meaningful description and detailed detection workflow. • Provides a strong commitment and intent to notify the DOM Office of Program Integrity immediately when any discovery of Fraud, Waste, or Abuse is detected. • Intentional and specific commitment to sharing trends of Fraud, Waste, and Abuse with DOM • While some parts of this section (see charts on pages 379/380) provide meaningful information, several parts lack detail of how certain important operations and activities will be executed and carried out. • Difficult to understand if the Offeror is referencing their internal Program Integrity Unit or the DOM Office of Program Integrity at times in this section.

Offeror D

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. The Offeror's process for notifying and educating providers of claims denials. **C. National Correct Coding Initiative (MississippiCAN)** 1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.	

[END OF SECTION]

Offeror D

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)

Response Limit: 10 pages

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including: a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division; b. Process for retrospective post payment recoveries of health-related insurance; c. Process for adjudicating claims involving third party coverage; d. Process for identifying, recouping, and releasing claims; e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP; f. Data analytics and informatics used to support the process; and, g. Process for providing supplemental third-party data and files to the Division. h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes. 2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best practices" to ensure that they are optimizing the TPL recoveries on behalf of the Division? a. If yes, describe the Offeror's process.	Notes: • Conducts "Path to Green" telephone calls with PI staff to maintain annual savings goals for each Medicaid market. • Although the MS team will maintain ultimate accountability and TPL oversight, there is no mention of internal process to validate TPL resources as inaccuracies cause inappropriate claim denials and recoupments.

Offeror D

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
B. Effectiveness 1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective. 2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.	

[END OF SECTION]

Offeror D

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)

Response Limit: 15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C(1)(e) (optional). Each appendix is limited to five (5) pages each.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. File Management 1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses. 2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including: a. Process for outreach and engagement of Members; b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program; and c. The Offeror's draft disenrollment survey. **B. Assignment of Members to a Primary Care Physician** 1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to: a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection; b. Track data to confirm that every Member is assigned; c. Inform PCPs/PCMHs of new Members within the required time frames; and d. Confirm that PCPs/PCMHs received the list of assigned Members.	Notes: • Sends membership card with instructions for changing PCP within 2 days of notification of new enrollment as the majority of PCPs are auto assigned • Sends text, email reminders, and/or postcards approximately 60 days before redetermination enrollment time and as a means of connecting to offer support, as this will support member retention • Offeror's daily process will generate reports that list Member-level activity and identifies any errors. MS Operations team will review the reports and investigate errors. • Offeror did not provide subcontractor details regarding timely processing of the member eligibility file, as subcontractors are required to meet the same requirements as the CCO.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members. 3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment. 4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs. 5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments. 6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments. **C. Member Information** 1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following: a. Language alternatives that will be available; b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract;	

Offeror D

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses; and d. Process for following up with Members whose information packets or identification cards are returned. e. Offeror may choose to include sample member materials in excess of the page limit.	

[END OF SECTION]
[END OF METHODOLOGY WORK QUESTIONNAIRE]

Offeror D

Innovation and Commitment (I&C)

From the RFQ:
Central to the Division's strategy for the next contract cycle are a number of new and/or improved initiatives it plans to implement. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans). The Offeror should also be attentive to standards and expectations described in Appendix A, Draft Contract, in designing its proposals.

After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.

As noted above, the total number of points available for responses to this subsection is 110 points. Points available per element of this subsection are included in the element's title.

Offeror D

I&C 4.2.3.1: Value-Based Purchasing (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a strategy to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. The program must describe how the CCOs will work collaboratively with the Division's subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. The Offeror must produce a Value-Based Purchasing proposal for the Division, considering the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • VBPs align with Physician Quality Improvement Payment Program (PQIPP) for improved CPT II reporting • Proposes to work collaboratively with DOM and other CCOs to host VBP campaigns to educate PCPs and PCMHs • Proposes incentives for Providers based on improvement activities • Details a PMPM Transformation Incentive Program for providers working towards PCMH recognition • Will utilize a VBP that is tied to specific code(s) • Offers diversified provider friendly VBP plans • Proposes to only report to DOM on an annual basis, should be more communication • Will only provide incentives to OB/GYNs for prenatal care when some prenatal care is rendered by non-OB/GYNs in rural areas • Failed to disclose any corporate VBP results

[END OF SECTION]

Offeror D

I&C 4.2.3.2: Patient-Centered Medical Home (PCMH) (10 Total Possible Points)
Response Limited: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle. PCMHs should be made available to all medium- and high-risk Members. The system is discussed more in Section 6.2.5, Patient-Centered Medical Homes, of Appendix A, Draft Contract. The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through with PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Documented a good understanding of the PCMH approach and their purpose • Will reimburse providers as a PCMH during the PCMH accreditation process • Detailed Practice coaching plan: Offeror will provide PCMH NCQA coaching sessions for all practices at any point during the performance year, conducted onsite or virtually. Table 4.2.3.2-1 Coaching plans will address Providers' individual needs. • Lacks detail regarding plan to expand PCMH in MS • Offeror encourages and supports PCMH accreditation, but primarily relies on providers to drive the PCMH accreditation process

[END OF SECTION]

Offeror D

I&C 4.2.3.3: Social Determinants of Health (20 Total Possible Points)

Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions: 1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data. 2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations? 3. What approaches will the Offeror take to address these challenges? 4. How will the Offeror address Health Equity through its SDOH programs? 5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)? Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches. **The Social Determinants of Health: Staffing table does not count against the Offeror's response limit to this question.**	Notes: • Dedicated to allocating 4% of annual profits into the community investment plan for the first 3 years of the contract • Details an extensive database to identify areas of SDOH concerns • Unique details of a provider incentive for SDOH screening • Insufficient detail on utilization of dashboard information and conversion into actionable steps

[END OF SECTION]

Offeror D

I&C 4.2.3.4: Value Added Benefits (10 Total Possible Points) (No page limit)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of Division-curated Value-Adds are included in Appendix E. The Offeror may choose from the Division's list of value-adds, describe some of their own, both, or elect not to include value-adds in its proposal. If no Value-Adds are included, the Offeror will receive a score of zero for this section. If offering any Value-Add in its response, the Offeror should make summary proposals of any and all Value- utilizing the following charts provided in Appendix E: • Value-Added Benefit: Summary Chart • Value-Added Benefit: Staffing (if applicable) If the Offeror is not including Value-Adds with its proposal, the Offeror should use the form provided in Appendix E as its answer to this request.	Notes: • Offers GED and high school diploma assistance for pregnant teenagers • Lacks sufficient detail • Underestimates utilization • Lacks specificity regarding who is eligible for value-add services

[END OF SECTION]

Offeror D

I&C 4.2.3.5: Performance Improvement Projects (10 Total Possible Points)

Response Limit: 4 PIP Proposals pages: 2 for CHIP and 2 for MSCAN + staffing pages (if applicable)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, both for the purposes of scalability and measurement. This is discussed more in Section 8, Quality Management, of Appendix A, Draft Contract. After selection, Contractors will submit their PIPs to the Division for standardization, and Contractors will be required to cross-collaborate on at least one PIP. The Offeror should include with its proposal summaries of its first year of proposed Performance Improvement Projects for MississippiCAN and CHIP. To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs utilizing the following charts provided in Appendix E: • Performance Improvement Project: Summary Chart • Performance Improvement Project: Staffing (if applicable)	Notes: • PIP for members with a dual diagnosis of behavioral health and substance abuse • Mentions a Collaborative PIP in title, but template only focuses on internal work plan, does not detail plans to work with other CCOs; therefore, response fails to address requirements of a collaborative PIP • Insufficient understanding of the MS population • Lacks SMART Goals. Overall, proposed PIPs are too broad, with too many interventions/activities, and too many measures to accurately track a successful PIP. • Missing key provider populations for education and training initiatives • Lack of innovative approaches in all proposed PIPs • Insufficient details of an overall communication strategy to DOM

[END OF SECTION]

Offeror D

I&C 4.2.3.6: Health Literacy Campaigns (10 Total Possible Points)
Response is limited to 4 campaigns + staffing pages if applicable

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The Division plans to coordinate a common strategy among Contractors in order to best amplify important health education to Members. More details can be found in Section 8.10.8, Health Literacy Campaigns, of Appendix A, Draft Contract. To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns utilizing the following charts provided in Appendix E: • Health Literacy Campaign: Summary Chart • Health Literacy Campaign: Staffing (if applicable)	Notes: • Health Literacy topics do not appear to be innovative

[END OF SECTION]

Offeror D

I&C 4.2.3.7: Telehealth (10 Total Possible Points)
Response Limit: 8 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals form Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.	Notes: • Will employ a dedicated telehealth program manager to work with providers • Details a plan to crosswalk NET data with claims analysis to find ways to redirect members to use telehealth when appropriate • Will work with schools to help maximize availability of a state funded telehealth grant to provide free services to students in 2022 • Will make telehealth kits for members to manage certain chronic conditions • Will utilize telehealth kiosks • Offers assurance that they will adhere to DOM's Admin Code and State Plan • Will allow use teledentistry for oral health emergencies for all ages • Contains a strong approach to serving behavioral health and SUD • Use of teledentistry for screening and preventive care in lieu of in person

[END OF SECTION]

Offeror D

I&C 4.2.3.8: Use of Technology (10 Total Possible Points)

Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs: 1. Data gathering and analysis 2. Efficacy of initiatives and programs 3. Transparency	Notes: • Thorough explanation of hot spotting and how DOM can use it

[END OF SECTION]

Offeror D

I&C 4.2.3.9: Potential Partnerships (10 Total Possible Points)

Response Limit: 8 partnerships total: 4 Potential Partnerships, 4 Potential Care Management Partnerships

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. This requirement is discussed through Appendix A, Draft Contract. The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners. The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs. This requirement is discussed in detail in Section 7, Care Management, of Appendix E. The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners. The Offeror may not duplicate potential partners in answering either part of this request. The Offeror should not include in its answer any information regarding any current or prior relationship with a proposed partner. The Offeror's explanation for choosing the Offeror should describe how work with the proposed partner directly connects to requirements of Appendix A, Draft Contract, and this RFQ, with no reference to any other contract or lines of business of the Offeror.	Notes: • Partnerships align with DOM needs • Funding and geographic reach does not appear to be adequate for all partnerships to be successful • Missed opportunity by not including the MS Dept of Education due to a large EPSDT population • Diaper Bank of the Delta partnership not statewide

[END OF SECTION]
[END OF INNOVATION & COMMITMENT]

Offeror D

Evaluation Team Consensus

Name	Signature and Date
Samantha Atkinson	Samantha Atkinson 5/23/2022 | 11:53:28 AM CDT
Dr. Catherine Brett	Catherine Brett 5/26/2022 | 2:23:05 PM CDT
Jennifer Grant	Jennifer Grant 5/20/2022 | 4:10:57 PM CDT
Keith Heartsill	Keith Heartsill 5/23/2022 | 10:18:18 AM CDT
Sharon Jones	Sharon Jones 5/25/2022 | 4:33:03 PM CDT
Evelyn Sampson	Evelyn Sampson 5/20/2022 | 2:16:21 PM CDT
Jennifer Wentworth	Jennifer Wentworth 5/20/2022 | 8:58:09 AM CDT

Management Factors Evaluation
Division of Medicaid Coordinated Care Organization RFQ
RFQ # 20211210
RFx # 3150003991

Offeror: Amerigroup Mississippi, Inc.

EVALUATION ROUND 2: MANAGEMENT FACTORS – MARKED/INFORMED CONSENSUS SCORE

Summary of Point Distribution by Section

RFQ Question Set Topic	Points Available	Score
Corporate Background and Experience		
Corporate Background: Biographical Information	20	14
Corporate Background: Corporate Resources	50	36
Corporate Experience	30	25
	100	**75**
Ownership and Financial Disclosure Information		
Information to be Disclosed	Pass/Fail	Pass
When and to Whom Information Will Be Disclosed	Pass/Fail	Pass
Information Related to Business Transactions	Pass/Fail	Pass
Change of Ownership	Pass/Fail	Pass
Disclosure of Identity of Any Person Convicted of a Criminal Offense	Pass/Fail	Pass
Audited Financial Statements	Pass/Fail	Pass
Organization and Staffing		
Organization	10	4
Job Descriptions and Responsibilities	20	9
Administrative Requirements	5	4
Staffing	25	13
Subcontractors	20	12
Economic Impact	20	14
	100	**56**
Management and Control		
Day-to-Day Management	Pass/Fail	Pass
Problem Management	Pass/Fail	Pass
Backup Personnel Plan	Pass/Fail	Pass
Emergency Preparedness Plan	Pass/Fail	Pass
Total Points	**200**	**131**

Offeror: Amerigroup Mississippi, Inc.

Rating Guide

Rating for Applicable Section	50 Points	30 Points	25 Points	20 Points	10 Points	5 Points
Excellent Value (100%) Response exceeds expectations on all aspects of requirements and at least satisfies all aspects of requirements.	50	30	25	20	10	5
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	24	20	16	8	4
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	18	15	12	6	3
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	12	10	8	4	2
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	6	5	4	2	1
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0	0	0

4.3.1 Corporate Background and Experience (100 points available)

From the RFQ:

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, and details of corporate experience relevant to the proposed Contract including all current or recent MississippiCAN, CHIP, or related projects.

4.3.1.1 Corporate Background

This section has two subparts:

- 4.3.1.1.1 Biographical Information
- 4.3.1.1.2 Corporate Resources

4.3.1.1.1: Corporate Background: Biographical Information (Marked): 20 Points Available

Response must be provided using the form included in Appendix F of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
See Appendix F, form entitled "Biographical Information"	Notes: • Commitment to attain all NCQA accreditations beyond basic distinction

4.3.1.1.2: Corporate Background: Corporate Resources (Marked): 50 Points Available

Response is limited to 40 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*

The Offeror may answer the following questions using narratives, charts, and lists as appropriate.
• Describe the Offeror's Computer and Technological Resources
• Describe the Offeror's Current Products and Services
• Describe the Offeror's Intangible Assets
• Describe any unique and/or innovative resources in which the Offeror specializes
• Describe additional resources of the Offeror
	Notes:
	• Offeror provided an extensive list of enhanced services to clients
	• Offeror included 13 of 17 value adds DOM sought
	• Offeror will meet providers where they are regarding VBP
	• Offeror will provide members with access to Telehealth Kiosk
	• Offeror will have SDOH Team with various specialties
	• Offeror plans for strong portal access for providers (24/7)
	• Offeror will include ancillary programs (i.e., diabetes prevention program (DPP))
	• Offeror will provide for medication delivery and the use of independent pharmacies
	• Offeror will utilize health equity mapping
	• Offeror plans for investments within Mississippi
	• Offeror's Disaster Recovery Plan is weak
	• Lacks detail in numerous areas, including but not limited to:
	  ○ Offeror provides limited details on validation of data warehouse
	  ○ Lacks detail on integration in the HIE and inbound data from the HIE
	  ○ Lacks detail on data transparency for DOM
	  ○ Offeror lacks details of access to MIS for DOM
	• Funding for Doula organizations
	• Partnership with Girl Scouts

4.3.1.2: Corporate Experience (Marked): 30 Points Available

Response must be provided using the form included in Appendix F of the RFQ (form entitled "Corporate Experience: Current and/or Recent Client.")
If the Offeror does not have the requested experience, then they must provide a narrative explanation not to exceed three (3) pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000. [Clarification about 400,000: The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.] If the information requested above is not available, the Offeror must provide a narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.	Notes: • Offeror showed diversity in populations served and density of populations • Offeror's diversity of demonstrated experience shows an understanding of the needs of the Mississippi Medicaid population

[END OF 4.3.1 CORPORATE BACKGROUND AND EXPERIENCE]

4.3.2 Ownership and Financial Disclosure Information

From the RFQ:

For many of the requirements of this section, the Offeror should utilize forms provided in Appendix G: Ownership and Financial Disclosure Information. If a form has been provided in this RFQ to respond to a requirement, no other response will be accepted.

4.3.2.1: Information to Be Disclosed (Marked): Pass/Fail

Response must be provided using the forms included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(b), the Offeror shall make certain disclosures. The Offeror must use the forms provided in Appendix G to provide this information. Titles of Forms that should be used: • Section 1: Ownership Interest and/or Managing Control Identification Information – subsections of that form: • Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification • Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control • Section 1(c): Familial Relationships • Section 2: Disclosure of Subcontractor Information • Section 3: Other Disclosing Entities	

4.3.2.2: When and to Whom Information Will be Disclosed (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times: 1. Upon the Contractor submitting a qualification in accordance with the State's procurement process; 2. Annually, including upon the execution, renewal, and extension of the contract with the State; and, 3. Within thirty-five (35) days after any change in ownership of the Contractor. In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency. The Offeror must use the appropriate form in Appendix G as its response to this section.	

4.3.2.3: Information Related to Business Transactions (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must use the appropriate form in Appendix G to provide this information. In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about: 1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and, 2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request. If the Offeror does not have information responsive to this request, then they should sign the attestation provided in Appendix G. If the Offeror does have information responsive to this request, they it should provide that information with the form(s) entitled Business Transactions with Subcontractors and Significant Business Transactions in Appendix G, as applicable.	

Offeror: Amerigroup Mississippi, Inc.

4.3.2.4: Change of Ownership (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A change of ownership of the Offeror includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Offeror. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. The Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor. Should the Contractor undergo a change of direct ownership, the Contractor must notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract. If the Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to the Division in writing within sixty (60) calendar days of the end of each quarter. If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract. **If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the appropriate attestation included in Appendix G as its response to this section. [emphasis added for Evaluator's convenience.]**	

Offeror: Amerigroup Mississippi, Inc.

4.3.2.5: Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 106 (a), the Contractor shall disclose to the Division the identity of any person who: 1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and, 2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. If the Offeror does have a disclosure to make that is responsive to this section, the Offeror must use the appropriate form in Appendix G to make that disclosure and respond to this section. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the attestation included in Appendix G as its response to this section.	

4.3.2.6: Audited/Financial Statements and Pro Forma Financial Template (Marked): Pass/Fail

Response must include information as described below. The Pro Forma Financial Template (referenced as "Three (3) year financial pro forma") was linked in Appendix G of the RFQ. ***NOTE: For the Evaluator's convenience, due to the voluminous nature of these documents, they are in a separate PDF document for each proposal.***

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Audited financial statements for the contracting entity shall be provided for each of the last three (3) years, including, at a minimum: 1. Statement of income; 2. Balance sheet; 3. Statement of changes in financial position during the last three (3) years; 4. Statement of cash flow; 5. Auditors' reports; 6. Notes to financial statements; and 7. Summary of significant accounting policies. If the information requested above is not available, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support the explanation. Acceptance of the explanation provided is at the discretion of the Division. The Offeror must also submit the following: 1. Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the qualification; and, 2. Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror. The Division reserves the right to request any additional information to assure itself of an Offeror's financial status.	Notes: • Total claims entirely accepted rate is 71.9%, which is below the expected rate • Reporting the highest MLR Admin Rate at almost 11.0%

[END OF 4.3.2, OWNERSHIP AND FINANCIAL INFORMATION]

4.3.3 Organization and Staffing

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state.

The Offeror is not allowed to list the name of staff in its response.

4.3.3.1 Organization (Marked): 10 Points Available

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The organization charts shall show: • Organization and staffing during each phase as described in the RFQ; • Full-time, part-time, and temporary status of all employees; and • Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared. For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."	Notes: • Offeror included both Implementation and Operational Organizational Phase Charts • Offeror presented a broad organizational chart that does not seem innovative • The organizational chart seems incoherent and mismatched for reporting staff • The vendor oversight manager reports to the CEO rather than the COO. This position has an operational, compliance, and fiscal function.

4.3.3.2 Job Description and Responsibilities of Key Positions (Marked): 20 Points Available

Response should use form in Appendix H for all positions listed below. The Offeror may not submit resumes or other information identifying current or prospective employees who are expected to fill the subject positions if the Offeror wins the contract.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
RFQ Instructions: The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract. The Offeror must use the appropriate form provided in Appendix H to respond to this request. **Positions required by Draft Contract Section 1.13 Administration Management, Facilities, and Resources provided for Evaluator's convenience.** **Draft Contract Section 1.13.1.1 Executive Positions** (refer to Draft Contract for full position description): 1. Chief Executive Officer 2. Chief Operating Officer 3. Chief Financial Officer 4. Medical Director 5. Perinatal Health Director 6. Behavioral Health Director 7. Chief Information Officer 8. Compliance Officer 9. Project Manager **Draft Contract Section 1.13.1.2 Administrative** Positions (refer to Draft Contract for full position description): 1. Provider Services Manager 2. Network/Contracting Manager 3. Member Services Manager	Notes: • Lack of collaboration among positions documented • Lack of requirements for specific roles, specifically minimum educational requirements, and continuing education requirements, for key personnel and clinical and professional staff (e.g., CIO position does not require continuing education or certifications, as IT standards continue to evolve) • Does not state minimum experience must include some Mississippi experience for majority of positions • Provider Services Manager Position did not mention management of provider representatives • The Quality and PIP Coordinator is required to have medical or behavioral health service license (RN/LPC/etc.) but limited educational requirements, and no continuing education requirements.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
4. Quality Management Director 5. Care Management Director 6. Population Health Director 7. Utilization Management Coordinator 8. Grievance and Appeals Coordinator 9. Claims Administrator 10. Data and Analytics Manager 11. Clinical Pharmacist **1.13.2 Additional Staff Requirements** The Contractor shall also have the following staff located in Mississippi by the beginning of the term of the Contract: 1. A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division; 2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-Network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations; 3. Designated staff to be responsible for Marketing, Member communications, and/or public relations; 4. Sufficient support staff to conduct daily business in an orderly manner (to respond to this question, the Division expects the Offeror to make its own determination regarding what sufficient support staff would be needed for daily business based on its knowledge of its own needs for operation); 5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times; 6. All Care Managers; and 7. A designee or designees who can respond to issues involving systems and	

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract	

4.3.3.3 Administrative Requirements (Marked): 5 Points Available

Response must be provided using the form included in Appendix H of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror will verify and answer the following: 1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201- 1399, as required by the RFQ. 2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives. The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.	

Offeror: Amerigroup Mississippi, Inc.

4.3.3.4 Staffing (Marked): 25 Points Available

Response is limited to 30 pages. In Amendment 4 (RFQ Q&A), Offerors were directed to assume a 125,000 Member enrollment in their CCO.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification. The Offeror will describe the following: 1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees. 2. Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees. 3. Describe staff who will be assigned to the quality management program and their qualifications. 4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a Member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers. 5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include whether the entity has successfully received accreditation for other state managed care programs, met required time	Notes: • Offeror includes extensive and diversified training modules that will be required for staff • Offeror will utilize a variety of diversified teams for services (figure 4.3.3.4-1) • Offeror undervalues the number of staff needed for the behavioral health line (1:125,000) • Offeror's use of shared national positions may be inappropriate for call centers and other key positions • Offeror fails to demonstrate a comprehensive understanding of the needs of the Mississippi market as it relates to staffing structure. • Offeror appears to be understaffed for the services to be provided, especially for "on-the-ground" services • 11% admin rate

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
frames to achieve accreditation, and any unsuccessful attempts. 6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications. 7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract. 8. Describe staff who will be responsible for subrogation and Third-Party Liability activities, including staffing levels and qualifications. 9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications. 10. Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared	

4.3.3.5 Subcontractors (Marked): 20 Points Available

Response must include a narrative of no more than three (3) pages and applicable form(s) from Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services. For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.	Notes: • Mississippi-based Vendor Oversight Manager

Offeror: Amerigroup Mississippi, Inc.

4.3.3.6 Economic Impact (Marked): 20 Points Available

Response must be provided using Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors. Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.	Notes: • Will reinvest 4% of annual profits into their Community Investment Plan for Mississippi in each of their first three years • Based on assumed 125,000 members, Offeror plans to hire 355 employees for Medicaid contract • $16.92 or better hourly minimum wages • Offeror described investments, but not what the economic impact to the state would be.

[END OF 4.3.3, ORGANIZATION AND STAFFING]

4.3.4 Management and Control

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

4.3.4.1 Day-to-Day Management (Marked): Pass/Fail

Response is limited to 20 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Program management approach; 2. Program control approach; 3. Manpower and time estimating methods; 4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable). 5. Management of performance standards, milestones, and/or deliverables; 6. Internal quality control monitoring; 7. Program status reporting, including examples of types of reports; and, 8. Approach to the Division's interaction with contract management staff.	

4.3.4.2 Problem Management (Marked): Pass/Fail

Response is limited to 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Assessment of program risks and approach to managing them; 2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and 3. Approach to problem identification and resolution.	

Offeror: Amerigroup Mississippi, Inc.

4.3.4.3 Backup Personnel Plan (Marked): Pass/Fail

Response is limited to 5 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff to allow for effective Division support	

4.3.4.4 Emergency Preparedness (Marked): Pass/Fail

Response is limited to 5 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of public enemy, occur during the life of the Contract.	

[END OF 4.3.4, MANAGEMENT AND CONTROL]

Offeror: Amerigroup Mississippi, Inc.

Evaluation Team Consensus

Name	Signature	Date
Samantha Atkinson	Samantha Atkinson	7/15/2022 | 2:52:06 PM CDT
Dr. Catherine Brett	Catherine Brett	7/15/2022 | 3:32:54 PM CDT
Jennifer Grant	Jennifer Grant	7/15/2022 | 2:55:18 PM CDT
Keith Heartsill	Keith Heartsill	7/15/2022 | 2:44:21 PM CDT
Sharon Jones	Sharon Jones	7/15/2022 | 2:53:58 PM CDT
Evelyn Sampson	Evelyn Sampson	7/15/2022 | 2:58:54 PM CDT
Jennifer Wentworth	Jennifer Wentworth	7/15/2022 | 2:37:50 PM CDT

Consensus Scoring: Magnolia Health Plan, Inc. (Magnolia)

Technical Factors Evaluation
Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991

Offeror E

EVALUATION ROUND 1: TECHNICAL FACTORS – BLIND SCORING CONSENSUS

Summary of Point Distribution by Section

RFQ Question Set Topic	Related Contract Section(s)	Possible Points	Score
Methodology/Work Statement			
Executive Summary		Pass/Fail	Pass
Member Services and Benefits	Covered Services and Benefits	50	48
Provider Services and Network	Provider Services	50	32
Care Management	Care Management	50	42
Quality Management	Quality Management	50	45
Utilization Management	Quality Management, Throughout the Draft Contract	50	45
Information Technology	Throughout the Draft Contract	20	13
Subcontractual Relationships and Delegation	Subcontractual Relationships and Delegation	20	10
Financial and Data Reporting	Throughout the Draft Contract	15	9
Program Integrity	Fraud, Waste, and Abuse. Throughout the Draft Contract	15	10
Subrogation and Third-Party Liability	Third-Party Liability	10	7
Eligibility, Enrollment, and Disenrollment	Eligibility, Enrollment, and Disenrollment	10	6
		340	**267**
Innovation and Commitment			
Value-Based Purchasing	Quality Management	20	15
Patient-Centered Medical Homes	Provider Services	10	7
Social Determinants of Health	Throughout the Draft Contract	20	9
Value-Adds		10	6
Performance Improvement Projects	Quality Management	10	5
Health Literacy Campaigns	Quality Management	10	5
Telehealth	Covered Services and Benefits	10	6
Use of Technology	Member Services, throughout the Draft Contract	10	7
Potential Partnerships	Throughout the Draft Contract	10	5
		110	**65**
Total Points		**450**	**332**

Offeror E

Rating Guide

Rating for Applicable Section	50 Possible Points	20 Possible Points	15 Possible Points	10 Possible Points
Excellent Value (100%) Response exceeds expectations for many or all aspects of requirements and at least satisfies all aspects of requirements.	50	20	15	10
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	16	12	8
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	12	9	6
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	8	6	4
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	4	3	2
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0

Offeror E

Executive Summary (Pass/Fail)
Response is limited to 10 pages

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Did the Executive Summary include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of: • Proposed work plan; • Staff organizational structure; • Key personnel; and, • A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements? 2. Did the Executive Summary demonstrate the Offeror's understanding of the Division's vision for the Contract?	

Offeror E

Methodology Work Questionnaire (MWQ)

Directions from the RFQ:

Please respond to the questions. These statements and questions relate directly to the Major Program Elements described in Section 1.3.7 of this RFQ and related requirements set forth in Appendix A, Draft Contract. Please respond completely but succinctly. When specified, page limits indicate the maximum length of a response. Offerors are encouraged to respond in fewer pages if that is possible. Indicate "not applicable" to any item that is not relevant to the Offeror's qualification. Required documentation for specific answers will not be included as part of page limits and should be included in the body of the response, not as an attachment, unless otherwise indicated.

Unless specified, questions apply to both MississippiCAN and CHIP. If the Offeror's processes and procedures will differ by program for any requested item, make that distinction in the answer.

The Offeror should not construe a Contract section's listing as "related," to denote that the section listed is the only section in which the Question Set Topic is mentioned. The Offeror is responsible to reading and understanding all parts of the Appendix A, Draft Contract, and using that information to be responsive to the Question Sets.

The Offeror is reminded of the prohibition against including identifying information in any of answers. Where model documents are requested, the Offeror must remove all identifying information. Failure to comply with this rule may be basis for disqualification.

Unless specified, questions apply to both MississippiCAN and CHIP. If the processes for both are the same, note that. If the processes are different, make the distinction.

As noted above, the total number of points available for responses to this subsection is 340 points. Points available per element of this subsection are included in the element's title.

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available

Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each.

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Delivery of Covered Services 1. Children a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following: i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach	Notes: • Will provide Adopt a School Program in high-risk, high-volume zip codes for members • Will work with schools to implement a school based electronic health (EHR) record solution • Identifies several community-based partnerships, working collaboratively with other CCOs and schools to help communicate with children/families. • Extensive listing of specific work responsibilities • Will focus on encouraging preventative services in children at the time of health risk screening and assessment • Will conduct new member orientation in-home within the first 90 days of enrollment • Will target PCPs and Pediatricians in addition to OBs for perinatal education for members. • Will incentivize PCPs & PCMHs for longer hours for CHIP members • Design of statewide Children's program is engaging to children and provides meaningful education to families to any child regardless of Medicaid eligibility • Well developed, concise, and meaningful structure with actionable information. • Innovative Ask Me 3 educational program for chronic conditions • Continuum of Support Chart is well structured

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, Immunizations, Well-Child visits, and any other services described in the CHIP State Health Plan. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children? 2. Behavioral Health Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral	• Dedicated Pediatrician with training in obesity medicine responsible for the diabetes program • Diabetes prediction model will not only rely on lab draws • Innovative eConsult solution available for a virtual provider to provider platform • Value Based Purchasing pilot in North MS for a virtual PCP platform • Dedicated foster care team with commitment to partner with CPS and DOM • Partner with Youth Villages to bring Intercept into the state for foster children • Foster Care Center of Excellence within the PCMH Program • Detailed Foster Care Transition Plan • Will provide expert behavioral health training for a large group of stakeholders • Relies on more person-to-person contact for information and training • Delivery of nutritious meals designed around disease state • Dedicated Autism Team up to age 19 to provide training assistance and healthcare needs for children with autism • Responder demonstrates understanding of MS and the needs of the MississippiCAN/CHIP population • Specified disease medicine in depression and understanding how mental health can impact your physical health

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
health/substance use disorder, including compliance with the SUPPORT Act. c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services? 3. Perinatal and Neonatal a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services. b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services. c. Describe any innovative methods that Offeror will use to augment its approach. d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services? 4. Chronic Conditions a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally. c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally. d. Describe any innovative methods that Offeror will use to augment its approach.	• Targeting specific mental health conditions and medication adherence • Partnership with Center for Advancement of Youth • Cellular enabled tablets for crisis stabilization for community stakeholders to provide on-demand access to behavioral clinicians • Behavioral Health Chat Bots for triage of mental health • Dedicated resources for children with low-risk mental health conditions • Will provide dentures for adults in need • Practice dental visits to aid with reduction in dental anxiety for developmentally disabled and other special needs patients • Incentive to Members for a dental exam • Will provide mobile dental and vision vans with providers • Will provide a new pair of glasses annually for all members over the age of 21 • Will provide polycarbonate lenses as a standard • Will be proactive in identifying pregnant members • Will ensure completion of Notice of Pregnancy Form at time of health risk screening • Will provide doula classes, virtual group prenatal classes and 24/7 lactation consultant • Will provide extensive cultural sensitivity and competency training for staff • Will assist members with online appointment scheduling and virtual assistance

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions? 5. Foster Children a. Describe the Offeror's experience and/or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs. b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population. c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in its efforts to accurately identify and subsequently serve the medical needs of foster children and youth. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children? 6. Dental Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services? 7. Vision Services	• The Offeror's 24-hour nurse advice line will use a warm transfer to 911 if required • No information about educational material being approved by DOM prior to distribution • Dependence on provider to access portals for care gap closure without any push notification/alert to the provider.

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services. b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding vision services? 8. Additional Items a. State whether the Offeror will required any cost-sharing or copayments from MississippiCAN and/or CHIP Members. i. If yes, please describe what these cost-sharing/copayment requirements will be. b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP). c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section. d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services. **B. Member Services Call Center** 1. Describe the Offeror's Member services call center operations, including: a. Confirming that the location of the proposed operations will be within the State of Mississippi (provide a yes or no answer; do not include address); b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
standards are met (the Division retains the right to approve all call center standards); c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available; d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled; e. Training program for call center employees including cultural competency and Care Management; f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime; g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week; 2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities. **C. Member Handbook** 1. Describe how the Offeror's Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services. 2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System? **D. Website and Mobile Application** 1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application. 2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any).	

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Member Education and Communication 1. Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use. 2. Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use. 3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including: a. An overview of the program, including accountabilities and proposed activities; b. The Offeror's rationale for selecting areas of focus; c. How the Offeror will ensure that materials are at a third (3rd) grade reading level; d. The language alternatives available to non-English speakers/readers; and, e. How Members who are visually and/or hearing impaired will be accommodated. 4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities. 5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe. 6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract. 7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104.	

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available. 8. Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services. 9. Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division. **F. Member Satisfaction** 1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties. **G. Member Appeals** 1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract; b. Process for expedited review; c. Involvement of Members and their families in the Grievance and Appeal process; d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements;	

Offeror E

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How Grievances are addressed prior to the filing of a Member appeal; and f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.	

[END OF SECTION]

Offeror E

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)

Response Limit: 45 pages, plus model provider contracts

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Provider Network 1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include: a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts; b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network; c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities; d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy; e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PMHCs' compliance with availability and scheduling appointment requirements and ensuring Members have	Notes: • Strong investment in provider development of quality practices with William Carey University • Significant collaboration and education for providers listed in proposal to increase synergy and health outcomes • Provider network development approach and provider retention strategy is strong and should maintain member access to care • Use of high touch-high tech strategies to recruit providers • Specialist incentives to make sure members have access to specialists and to recruit and retain specialists within the network • Collaboration with RTFs and ITFs on timely notice of admissions o MOU with providers regarding on-site psychiatric services • Collaboration with DOM and CCOs to identify uniform approaches to UM, which will reduce provider administrative burden and improve the process • Proposed claims payment process potentially leads to a four-month delay in timely payment of clean claims • The proposal identifies high tech strategies, but did not address providers lacking high tech capabilities or resources • Sample contracts allow for binding arbitration, which is not authorized by DOM

Offeror E

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and, f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network. g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy. 2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities. 3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. 4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete. 5. Submit templates of the Offeror's standard Provider contracts. 6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including: a. System used to identify and notify Members affected by Provider loss;	

Offeror E

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
b. Automated systems and membership supports used to assist affected Members with Provider transitions; c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition; and, d. Approach to cover membership needs with existing network resources following terminations. 7. Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care. 8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to: a. Issue IRS 1099 forms, b. Meet all federal and Division reporting requirements, and c. Cross-reference to state and federal identification numbers to identify and report excluded Providers. **B. Provider Services Call Center** 1. Describe the Offeror's Provider services call center operations including: a. Hours of operation; b. Describe how the Offeror will ensure call center employees will have cultural competency; c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards);	

Offeror E

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
d. Training program for call center employees including local and statewide cultural competency; and, e. A description of any plans to use electronic communication to respond to Provider inquiries. 2. Describe how the Offeror will assess the quality and efficiency of the Call Center. **C. Provider Education and Communication** 1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system. 2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a Member for behavioral health/substance use disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems. 3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections. 4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics. 5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.	

Offeror E

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties. 7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services. 8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances: a. Perinatal; b. Behavioral Health; c. Substance Use Disorder; d. Chronic Conditions; and e. Foster Children. **D. Collaboration with Providers** 1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity. 2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care. 3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members.	

Offeror E

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Provider Payment 1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis. 2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Offeror's claims processing system. 3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s). **F. Provider Grievances and Appeals** 1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract; b. Process for elevating Provider Grievances; and, c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.	

[END OF SECTION]

Offeror E

MWQ 4.2.2.3: Care Management (50 Total Possible Points)

Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages.

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Care Management Proposal 1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response: a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach; b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities; c. How the Offeror will ensure that Care Management is a tool to address health equity concerns; d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and, e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high). **B. Stratification and Assignment** 1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking	Notes: • Appears to have a well thought out and comprehensive engagement model for members. • Consistency across benefits for both MississippiCAN and CHIP • Enhanced partnerships with MS community pharmacists to close care gaps • Strong details around the foster care population: ○ Dedicated FC Manager ○ Innovative care kits (including duffle bag and personal care items like ear buds and blankets) ○ Unique access for adoptive parents on the child's health care needs and care plan ○ Assesses adoptive family's needs and home environment (including assessment of non-member children in home overdue for wellness activities like immunizations) • Strong details around Risk Screening and stratification: ○ New member in-home visits first 90 days of enrollment ○ Leverages diverse access points (ex. providers and other/community resources) to help the Care Manager complete the HRS ○ Unique and extensive array of predictive modeling tools ○ The Offeror details a thoughtful plan for continued assessment and reassessment of all risk-levels of beneficiaries, including weekly re-assessment for evolving risk. • Unique plan to deploy "Trusted Messengers" to outreach members (ex. at homeless shelters) and to provide healthcare education

Offeror E

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
answers, and how answers will be used for stratification of Members based on acuity levels and Care Management. 2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management. 3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment with the Offeror in order to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment. 4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools. 5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA. **C. Care Management Services** 1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will	• Detail dedicated Care Management for low-risk members and resources dedicated to low-risk members • Details coordination with other CCOs to reduce hospital readmissions by improving discharge planning at admission • Details in-home medication evaluation as a tool in medication adherence and reducing hospital readmission • Complete CM for entire state: o Partnership with vendor to address chronic conditions in all eighty-two counties o Statewide coverage plan for the community-based services. • Details plan of engagement to connect members to care management who are normally resistant to participation • Dependence on provider to access portals for care gap closure without any push notification/alert to the provider • Insufficient details of an overall communication strategy to DOM

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
notify Members and/or Providers when follow-up is due. Address the following issues in the response: a. Facilitation and monitoring of Member compliance with treatment plans; b. Partnerships of community-based partnerships and other state agencies; and c. Coordination with other Providers. 2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in identifying and gaining access to community resources that may provide services not covered. 3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response: a. The Offeror's role and the PCP's/PCMH's role in this process; b. Examples of information that the Offeror will provide to Providers; c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and, d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation. e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties. **D. Transition of Care** 1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process. 2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including: a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services; b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff; c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and, d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and network pharmacist to assure continuation of needed therapy. 3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation.	

Offeror E

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Staff 1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following: a. Education and training required for Care Managers; b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers; c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases; d. And overview of the Offeror's continuing education and training plan for its Care Managers; and e. Expected wages to be paid to Care Managers (hourly/salary and what amounts). **F. Hypotheticals** 1. Describe the Offeror's approach to providing Care Management in the following scenarios: a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months; b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable; c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
needs was admitted last night to a local inpatient facility after presenting with an asthma attack; d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week; and, e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a Member.	

[END OF SECTION]

Offeror E

MWQ 4.2.2.4: Quality Management (50 Total Possible Points)

Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to 10 pages.

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Quality Management Program 1. Describe the Offeror's proposed quality management program, including: a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable; b. The program's lines of accountability; c. Process for selecting areas of focus; d. Process for using evidence-based practices; e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy; f. Use of data to design, implement and evaluate the effectiveness of the program; g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and h. How the Offeror will address health access and equity in its quality management program 2. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages). **B. Clinical Guidelines and Compliance** 1. Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines.	Notes: • Proposed partnership with other CCOs to lead creation of a statewide health equity guide • Proposed partnership with other CCOs to lead the standardization of printed policy manuals • Detailed description of each committee and subcommittee with appropriate meeting timeline for each subject matter • Strong and specific details of how the offeror will align with the Comprehensive Quality Strategy • Extensive and thorough outline for evaluation of the quality management program • Extensive list of Clinical Practice Guidelines covering full breadth of conditions effecting MS • Extensive detail of utilization of data platforms to drive quality programming • Internal data validation process is well described • Strong detail in sample workplan Establishment of the Foundation for Advancing Health Equity and their partnership with Jackson State University • Unique description of Health Equity and SDOH Dashboards • Clinical Practice Guidelines incorporated in the Single-Case Agreements • PPCs incorporated as part of the quality review • Evidence of strong understanding of the state of Mississippi

Offeror E

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 3. Describe the Offeror's proposed process for compliance with the SUPPORT Act. 4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 5. Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered. 6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers. 7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for precluding payment to Providers and reporting to the Division via encounter data in accordance with 42 C.F.R. § 438.3. 8. Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions. **C. Quality Measurement** 1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract. a. Describe the type of build necessary to create these types of reports.	

Offeror E

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidences efficacy of programs.	

[END OF SECTION]

Offeror E

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)

Response Limit: 30 pages

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to utilization management, including: a. A description of the utilization management program; b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures; 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 used to develop utilization review criteria; e. Expected Prior Authorization clinical criteria by program area; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates; g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization; h. The Offeror's approach to reducing the number of Prior Authorizations required; i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and	Notes: • Strong understanding of the entire UM process and purpose of UM • Provides exceptional detail regarding the oversight and accountability structure of the UM process • Will incorporate use of cross-functional UM processes • Plans to use smart electronic PA forms • Implementation of a preferred provider program to waive PA requirements for high-quality providers • Plans to utilize an internal real-time monitoring process of the UM program • Will conduct weekly and bi-weekly UM rounds that focus on specific Medicaid Programs • Provides a UM staffing structure that specifies review staff will be MS licensed and will have the appropriate credentials for the review type • Demonstrates thorough understanding of review process and expected turnaround time requirements, as evidenced by the charts on pages 321 and 322 • Exceptional understanding of the review process that involves incomplete submissions by Providers causing a pended status with a request for additional information • Well written policy and procedures for overall PA Process demonstrates thorough understanding of UM • Details a plan to have a well-organized public website

Offeror E

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
j. Processes to ensure consistent application of criteria by individual clinical reviewers. **B. Methods** 1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy. 2. Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program. 3. Describe how the Offeror will identify and address trends in over- and under-utilization. 4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members. 5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.	• Post Discharge plans will correlate with the Quality Improvement Payment Program (QIPP) Potentially Preventable Hospital Returns (PPHR) • Provides a thorough list of strategies that incorporate pharmacies • Innovative strategies to connect Members and PCPs for ED Avoidance • Evidence of understanding the Quality Improvement Payment Program (QIPP) post discharge program, that is detailed on page 332 • Will utilize PBA data to reduce cost as part of their UM process • Plans to collaborate with other CCOs regarding PA processes • Provides a chart that details the clinical criteria that will be used for the various review types • Lacks specificity about alerting or notifying DOM of utilization data • Dependence on provider to access portals for care gap closure without any push notification/alert to the provider. • Lacks specificity regarding out of network provider notifications, which indicates they are only provided through the provider manual and the member handbook to alert out of network providers of the need for authorizations and single case agreements • Lacks specificity that supports the Offeror's PA process will not be more stringent than DOM's

[END OF SECTION]

Offeror E

MQW 4.2.2.6: Information Technology (20 Total Possible Points)

Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages.

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Claims Processing 1. Describe the Offeror's claims processing system including: a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program. 2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion. 3. Describe the Offeror's claims processing operations including: a. The claims processing systems that will support this program; b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program; c. The Offeror's process for dealing with discovered compliance issues through an expedited process; d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an	Notes: • Ability to adjust system for DOM needs without delay, but notes conditions (such as size, complexity, impact on other systems, etc.) • Integrates all systems, including member data and care management in one system • Use of innovative technological tools for members and providers • Expanding to three data centers for enhanced levels of service and resiliency continuity of operations • Production data immediately replicated in the associated recovery data center • Leverage back up data and infrastructure to continue essential business functions in times of need • Demonstrates clear understanding of information technology and processes • MDCPS access to web portals • Strong continuity of operations and disaster recovery planning • Figure 4.2.2.6.A.1.a does not show the subcontractor encounter data input • Information technology section should have included more information regarding the encounter data processing • Little information about sharing data with DOM

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
example of how the Offeror has addressed these deficiencies or variances. **B. Technological Systems** 1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System. 2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies. 3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate. 4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies. **C. Innovation** 1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members. 2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network. 3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division. **D. Continuity of Operations**	

Offeror E

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including a. Employee training; b. Essential business functions and responsible key employees; c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; d. Communication with staff and suppliers when normal systems are unavailable; e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components; f. Security and privacy requirements; and g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.	

[END OF SECTION]

Offeror E

MQW 4.2.2.7: Subcontractual Relationships and Delegation (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Services to be Subcontracted 1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor. 2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor. **B. Subcontractor Oversight** 1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will: a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor; b. Ensure receipt and reconciliation of all required data including encounter data; c. Ensure appropriate utilization of health care services; d. Ensure delivery of administrative and health care services meets all standards required by this RFQ; e. Ensure adherence to required Grievance policies and procedures; and, f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how	Notes: • Subcontractors will have NCQA or URAC accreditation • Includes DOM as a participant in bi-weekly subcontractor encounter meetings • Did not include TPL subcontractor in listing • Review of subcontractors is limited to annual, rather than more frequently

Offeror E

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
the Offeror has addressed a deficiency or contractual variance with a Subcontractor. g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division. h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.	

[END OF SECTION]

Offeror E

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)
Response Limit: 20 pages

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Financial Reporting 1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c). 2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized. **B. Data Reporting** 1. Encounter Data a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan. 2. Health Information System Data a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes,	Notes: • Documents the ability to meet DOM's overall required financial reporting needs very well • Expresses a good understanding of encounters in their flow diagram • Will assist DOM with reconciliations of encounters to the Cash Disbursements Journal (CDJ) • Four-pronged approach should be beneficial for provider encounter submission • Incentives for encounter submission are tied to the providers VBP • Details on MLR reporting are lacking

Offeror E

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
integrates, validates, and reports data including but not limited to the following areas: i. Utilization, ii. Claims, Grievances and Appeals, iii. Disenrollment (for other than loss of Medicaid eligibility), iv. Member Characteristics, v. Provider Characteristics, vi. Care Management Utilization, vii. Clinical Data, and viii. Population Health.	

[END OF SECTION]

Offeror E

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)
Response Limit: 20 Pages

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Fraud, Waste, and Abuse 1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including: a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable; b. Process for acting upon suspected cases of fraud, waste and abuse; c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers; d. Process for interacting with the Division, including the Office of Program Integrity; and, e. Other components of the Offeror's fraud, waste, and abuse program. **B. Claim Denials** 1. Describe the Offeror's proposed Denials Review and Reporting program, including: a. A description of the Offeror's Denials Management program; b. A summary/listing of the Offeror's denials criteria/protocol; c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria; d. The Offeror's reconsideration process as it relates to claims denials; and	Notes: • Proposal describes planned and routine engagement with CMS OIG and active participation in national taskforces for Fraud, Waste, Abuse and Control • Proposal commits to a dedicated MS compliance officer, compliance committee, and a separate Fraud, Waste, and Abuse workgroup • Requires immediate staff training for Fraud, Waste, and Abuse for new employees and reeducation periodically for continuous employees; the proposal also lists the components they expect employees to be knowledgeable about to prevent FWA • Will have required FWA training during new provider training and includes subcontractors • Proposal provides detailed proactive and reactive FWA detection plan for operations • Well-designed process for referral and reporting to OPI Online reconsideration process for claims denial section • Weekly review of denied claims • Incorrectly or denied claims are resolved within 30 days. • A variety of ways that providers can learn about the denial process, including monthly meetings with the top ten providers • Evidences clear understanding of and commitment to configure NCCI custom edits to comply with both DOM custom rules and national standards • Requires vendors to update their software within sixty days after an NCCI file release

Offeror E

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. The Offeror's process for notifying and educating providers of claims denials. **C. National Correct Coding Initiative (MississippiCAN)** 1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.	

[END OF SECTION]

Offeror E

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)
Response Limit: 10 pages

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including: a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division; b. Process for retrospective post payment recoveries of health-related insurance; c. Process for adjudicating claims involving third party coverage; d. Process for identifying, recouping, and releasing claims; e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP; f. Data analytics and informatics used to support the process; and, g. Process for providing supplemental third-party data and files to the Division. h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes. 2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best practices" to ensure that they are optimizing the TPL recoveries on behalf of the Division? a. If yes, describe the Offeror's process.	Notes: • Clear understanding of the TPL process and DOM's needs • Offeror will provide DOM with reasonable access to required operational data through their Cloud Reporting Suite. Access to CCO platforms gives DOM a better understanding of CCO processes. • Proposal states that when a match is found, the Offeror will verify coverage directly with the carrier through a combination of online tools and telephone contact and send the resulting data back. This aligns with DOM's goal of eliminating inaccurate claim denials and recoupments. • Proposal states that the local health plan leadership will collaborate with their parent company's COB Center of Excellence to develop and implement innovative TPL approaches that help contain health costs and reduce Provider administrative burden. • Detailed information regarding TPL collections and recovery measures reflected in Table 4.2.2.10.A.2.a and Table 4.2.2.10.B.2

Offeror E

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
B. Effectiveness 1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective. 2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.	

[END OF SECTION]

Offeror E

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)

Response Limit: 15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C(1)(e) (optional). Each appendix is limited to five (5) pages each.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. File Management 1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses. 2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including: a. Process for outreach and engagement of Members; b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program; and c. The Offeror's draft disenrollment survey. **B. Assignment of Members to a Primary Care Physician** 1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to: a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection; b. Track data to confirm that every Member is assigned; c. Inform PCPs/PCMHs of new Members within the required time frames; and d. Confirm that PCPs/PCMHs received the list of assigned Members.	Notes: • Innovative - Conducts new member in home welcome visits • Works with expectant mothers to select baby PCP 60 days before expected delivery date • Helps members with special needs find a PCP • Failure to state timeline of distribution/availability of void, disenrollment, pregnancy, and foster care reports to identified entities/areas • Offeror did not provide subcontractor details regarding timely processing of the member eligibility file, as subcontractors are required to meet the same requirements as the CCO

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members. 3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment. 4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs. 5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments. 6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments. **C. Member Information** 1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following: a. Language alternatives that will be available; b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract;	

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses; and d. Process for following up with Members whose information packets or identification cards are returned. e. Offeror may choose to include sample member materials in excess of the page limit.	

[END OF SECTION]

[END OF METHODOLOGY WORK QUESTIONNAIRE]

Offeror E

Innovation and Commitment (I&C)

From the RFQ:

Central to the Division's strategy for the next contract cycle are a number of new and/or improved initiatives it plans to implement. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans). The Offeror should also be attentive to standards and expectations described in Appendix A, Draft Contract, in designing its proposals.

After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.

As noted above, the total number of points available for responses to this subsection is 110 points. Points available per element of this subsection are included in the element's title.

Offeror E

I&C 4.2.3.1: Value-Based Purchasing (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a strategy to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. The program must describe how the CCOs will work collaboratively with the Division's subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. The Offeror must produce a Value-Based Purchasing proposal for the Division, considering the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Includes a list of stakeholders they already consider for VBP arrangements • Incentives available for providers tied to the factors providers directly control • Incentives available for PCMH practices to integrate behavioral health into the model • PCP incentives available for SDOH that are tied to utilization of Z Codes • Will offer Provider incentive bonus for preventive services to children in foster care • Strong chronic condition management program that will be active in all eighty-two counties

[END OF SECTION]

Offeror E

I&C 4.2.3.2: Patient-Centered Medical Home (PCMH) (10 Total Possible Points)
Response Limited: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle. PCMHs should be made available to all medium- and high-risk Members. The system is discussed more in Section 6.2.5, Patient-Centered Medical Homes, of Appendix A, Draft Contract. The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through with PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Documented a good understanding of PCMH approach and their purpose • Offeror will assign a designated PCMH director to work with prospective and existing PCMHs • Presently 65% of MS FQHCs are HRSA recognized as having PCMH recognition. This Offeror's goal is to see 100% of CHCAMS' FQHCs attain PCMH recognition from NCQA. Increase all PCMH recognition for private PCPs in the first 18 months of contract execution. Offeror plans to partner with other CCOs for standardized training • Planned use of corrective action plans to ensure quality performance • Quarterly meetings with every PCMH • Reliance on the provider to utilize the portal for gap review. Although secure, the portal is not always perceived by the provider as easy access.

[END OF SECTION]

Offeror E

I&C 4.2.3.3: Social Determinants of Health (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions: 1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data. 2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations? 3. What approaches will the Offeror take to address these challenges? 4. How will the Offeror address Health Equity through its SDOH programs? 5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)? Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches. **The Social Determinants of Health: Staffing table does not count against the Offeror's response limit to this question.** •	Notes: • Three local/regional Community Impact Councils to address SDOH and health disparities activities • Insufficient detail on actionable steps of the SDOH Strategy • Did not exhibit a clear understanding of the SDOH models uses in the proposal

[END OF SECTION]

Offeror E

I&C 4.2.3.4: Value Added Benefits (10 Total Possible Points) (No page limit)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of Division-curated Value-Adds are included in Appendix E. The Offeror may choose from the Division's list of value-adds, describe some of their own, both, or elect not to include value-adds in its proposal. If no Value-Adds are included, the Offeror will receive a score of zero for this section. If offering any Value-Add in its response, the Offeror should make summary proposals of any and all Value- utilizing the following charts provided in Appendix E: • Value-Added Benefit: Summary Chart • Value-Added Benefit: Staffing (if applicable) If the Offeror is not including Value-Adds with its proposal, the Offeror should use the form provided in Appendix E as its answer to this request.	Notes: • Will provide Care Kits • Member education covers English as a second language class (helps with health care literacy) • Will offer enhanced NET services that include trips to grocery store and food pantry • Stated utilization numbers seem severely underestimated • Lacks specificity regarding the "baby shower" to understand the impact • Lacks commitment for the amount of money it would take to help the population of MS • Missed opportunities to make a meaningful impact

[END OF SECTION]

Offeror E

I&C 4.2.3.5: Performance Improvement Projects (10 Total Possible Points)

Response Limit: 4 PIP Proposals pages: 2 for CHIP and 2 for MSCAN + staffing pages (if applicable)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, both for the purposes of scalability and measurement. This is discussed more in Section 8, Quality Management, of Appendix A, Draft Contract. After selection, Contractors will submit their PIPs to the Division for standardization, and Contractors will be required to cross-collaborate on at least one PIP. The Offeror should include with its proposal summaries of its first year of proposed Performance Improvement Projects for MississippiCAN and CHIP. To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs utilizing the following charts provided in Appendix E: • Performance Improvement Project: Summary Chart • Performance Improvement Project: Staffing (if applicable)	Notes: • Extensive and thorough description of PIPs. • Demonstrates understanding of CQS by selection of PIPs proposed. • Obesity PIP provides excellent detail with narrowed scope, well thought out assessment tools and metrics • Selection of metrics that correlate well to the stated goals in all PIPs • Selection of appropriate measurement of impact metrics are narrow in scope and will be accessible through available data • Response fails to address requirements of a collaborative PIP • Lacks SMART goals • Insufficient details of an overall communication strategy to DOM

[END OF SECTION]

Offeror E

I&C 4.2.3.6: Health Literacy Campaigns (10 Total Possible Points)
Response is limited to 4 campaigns + staffing pages if applicable

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The Division plans to coordinate a common strategy among Contractors in order to best amplify important health education to Members. More details can be found in Section 8.10.8, Health Literacy Campaigns, of Appendix A, Draft Contract. To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns utilizing the following charts provided in Appendix E: • Health Literacy Campaign: Summary Chart • Health Literacy Campaign: Staffing (if applicable) •	Notes: • Ask Me 3 Program has broad application • Health Literacy topics do not appear to be innovative • Health Literacy campaigns do not provide as much detail on any of the programs as expected

[END OF SECTION]

Offeror E

I&C 4.2.3.7: Telehealth (10 Total Possible Points)
Response Limit: 8 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals form Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.	Notes: • Will rely on lessons learned during the pandemic about telehealth utilization and how to apply strategies going forward • Offers use of internet enabled tablets to allow certain rural providers, law enforcement and paramedics to reach behavioral health clinicians on demand • Will partner with AT&T for broadband service • Will provide several virtual options for Members to access care, which include doulas, group prenatal care, pregnant women with SUD and pilot primary care program in 15 counties in northwest MS • Will utilize Remote Patient Monitoring for 12 chronic conditions statewide • Will use Safe Link to provide smart phones • Lacks specificity on how to close the tech gap with providers • Lacks specificity on how they plan to close the tech gap through tech assistance for members

[END OF SECTION]

Offeror E

I&C 4.2.3.8: Use of Technology (10 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs: 1. Data gathering and analysis 2. Efficacy of initiatives and programs 3. Transparency	Notes: • Provides DOM with appropriate access to data in the cloud reporting suite • Offeror has a centralized data science organization • Provider access to Z Code utilization dashboard • MIS design is in line with CMS MITA requirements

[END OF SECTION]

Offeror E

I&C 4.2.3.9: Potential Partnerships (10 Total Possible Points)

Response Limit: 8 partnerships total: 4 Potential Partnerships, 4 Potential Care Management Partnerships

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. This requirement is discussed through Appendix A, Draft Contract. The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners. The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs. This requirement is discussed in detail in Section 7, Care Management, of Appendix E. The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners. The Offeror may not duplicate potential partners in answering either part of this request. The Offeror should not include in its answer any information regarding any current or prior relationship with a proposed partner. The Offeror's explanation for choosing the Offeror should describe how work with the proposed partner directly connects to requirements of Appendix A, Draft Contract, and this RFQ, with no reference to any other contract or lines of business of the Offeror.	Notes: • MS SIDS, an infant safety program, is a strong partnership for Medicaid • Only one state-wide partnership of the eight listed • Missed opportunity by not including the MS Department of Education due to a large EPSDT population

[END OF SECTION]

[END OF INNOVATION & COMMITMENT]

Offeror E

Evaluation Team Consensus

Name	Signature and Date
Samantha Atkinson	Samantha Atkinson 5/23/2022 | 11:54:40 AM CDT
Dr. Catherine Brett	Catherine Brett 5/26/2022 | 2:23:45 PM CDT
Jennifer Grant	Jennifer Grant 5/20/2022 | 4:11:37 PM CDT
Keith Heartsill	Keith Heartsill 5/23/2022 | 10:28:36 AM CDT
Sharon Jones	Sharon Jones 5/25/2022 | 4:32:03 PM CDT
Evelyn Sampson	Evelyn Sampson 5/20/2022 | 2:15:48 PM CDT
Jennifer Wentworth	Jennifer Wentworth 5/20/2022 | 8:58:37 AM CDT

Management Factors Evaluation
Division of Medicaid Coordinated Care Organization RFQ
RFQ # 20211210
RFx # 3150003991

Proposer: Magnolia Health Plan, Inc.

EVALUATION ROUND 2: MANAGEMENT FACTORS – MARKED/INFORMED CONSENSUS SCORE

Summary of Point Distribution by Section

RFQ Question Set Topic	Points Available	Score
Corporate Background and Experience		
Corporate Background: Biographical Information	20	12
Corporate Background: Corporate Resources	50	26
Corporate Experience	30	24
	100	**62**
Ownership and Financial Disclosure Information		
Information to be Disclosed	Pass/Fail	Pass
When and to Whom Information Will Be Disclosed	Pass/Fail	Pass
Information Related to Business Transactions	Pass/Fail	Pass
Change of Ownership	Pass/Fail	Pass
Disclosure of Identity of Any Person Convicted of a Criminal Offense	Pass/Fail	Pass
Audited Financial Statements	Pass/Fail	Pass
Organization and Staffing		
Organization	10	3
Job Descriptions and Responsibilities	20	12
Administrative Requirements	5	4
Staffing	25	7
Subcontractors	20	12
Economic Impact	20	10
	100	**48**
Management and Control		
Day-to-Day Management	Pass/Fail	Pass
Problem Management	Pass/Fail	Pass
Backup Personnel Plan	Pass/Fail	Pass
Emergency Preparedness Plan	Pass/Fail	Pass
Total Points	**200**	**110**

Proposer: Magnolia Health Plan, Inc.

Rating Guide

Rating for Applicable Section	50 Points	30 Points	25 Points	20 Points	10 Points	5 Points
Excellent Value (100%) Response exceeds expectations on all aspects of requirements and at least satisfies all aspects of requirements.	50	30	25	20	10	5
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	24	20	16	8	4
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	18	15	12	6	3
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	12	10	8	4	2
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	6	5	4	2	1
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0	0	0

4.3.1 Corporate Background and Experience (100 points available)

From the RFQ:

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, and details of corporate experience relevant to the proposed Contract including all current or recent MississippiCAN, CHIP, or related projects.

4.3.1.1 Corporate Background

This section has two subparts:

- 4.3.1.1.1 Biographical Information
- 4.3.1.1.2 Corporate Resources

4.3.1.1.1: Corporate Background: Biographical Information (Marked): 20 Points Available

Response must be provided using the form included in Appendix F of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
See Appendix F, form entitled "Biographical Information"	

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4.3.1.1.2: Corporate Background: Corporate Resources (Marked): 50 Points Available

Response is limited to 40 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror may answer the following questions using narratives, charts, and lists as appropriate. • Describe the Offeror's Computer and Technological Resources • Describe the Offeror's Current Products and Services • Describe the Offeror's Intangible Assets • Describe any unique and/or innovative resources in which the Offeror specializes • Describe additional resources of the Offeror	Notes: • Offeror included 10 of the 17 value-adds DOM sought (e.g., 90 day wound care available post-partum) • Offeror will utilize three redundant geographically separate data centers • Offeror provided a strong disaster recovery plan • Offeror plans to include information in statewide HIE • Offeror will utilize SchoolCare software which will allow school-based nurses to document care • Offeror misses opportunity for member healthcare impact by limiting partnership (e.g., independent pharmacies only leveraged for A1C testing as opposed to all retail pharmacies; non-statewide maternity initiatives) • Offeror lacks innovation outside of RFQ/Contract requirements • Offeror lacks detail of current products and services • Offeror lacks a response regarding intangible assets • Offeror provided an incomplete response to unique and innovative resources • Offeror demonstrates a reliance on paper mailings for gap closure and quality improvement activities versus using diverse methods of communication

4.3.1.2: Corporate Experience (Marked): 30 Points Available

Response must be provided using the form included in Appendix F of the RFQ (form entitled "Corporate Experience: Current and/or Recent Client.")
If the Offeror does not have the requested experience, then they must provide a narrative explanation not to exceed three (3) pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000. [Clarification about 400,000: The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.] If the information requested above is not available, the Offeror must provide a narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.	Notes: • Offeror's diversity of demonstrated experience shows an understanding of the needs of the Mississippi Medicaid population

[END OF 4.3.1 CORPORATE BACKGROUND AND EXPERIENCE]

4.3.2 Ownership and Financial Disclosure Information

From the RFQ:

For many of the requirements of this section, the Offeror should utilize forms provided in Appendix G: Ownership and Financial Disclosure Information. If a form has been provided in this RFQ to respond to a requirement, no other response will be accepted.

4.3.2.1: Information to Be Disclosed (Marked): Pass/Fail

Response must be provided using the forms included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(b), the Offeror shall make certain disclosures. The Offeror must use the forms provided in Appendix G to provide this information. Titles of Forms that should be used: • Section 1: Ownership Interest and/or Managing Control Identification Information – subsections of that form: • Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification • Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control • Section 1(c): Familial Relationships • Section 2: Disclosure of Subcontractor Information • Section 3: Other Disclosing Entities	

4.3.2.2: When and to Whom Information Will be Disclosed (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times: 1. Upon the Contractor submitting a qualification in accordance with the State's procurement process; 2. Annually, including upon the execution, renewal, and extension of the contract with the State; and, 3. Within thirty-five (35) days after any change in ownership of the Contractor. In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency. The Offeror must use the appropriate form in Appendix G as its response to this section.	

4.3.2.3: Information Related to Business Transactions (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must use the appropriate form in Appendix G to provide this information. In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about: 1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and, 2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request. If the Offeror does not have information responsive to this request, then they should sign the attestation provided in Appendix G. If the Offeror does have information responsive to this request, they it should provide that information with the form(s) entitled Business Transactions with Subcontractors and Significant Business Transactions in Appendix G, as applicable.	

4.3.2.4: Change of Ownership (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A change of ownership of the Offeror includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Offeror. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. The Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor. Should the Contractor undergo a change of direct ownership, the Contractor must notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract. If the Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to the Division in writing within sixty (60) calendar days of the end of each quarter. If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract. **If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the appropriate attestation included in Appendix G as its response to this section. [emphasis added for Evaluator's convenience.]**	

Proposer: Magnolia Health Plan, Inc.

4.3.2.5: Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 106 (a), the Contractor shall disclose to the Division the identity of any person who: 1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and, 2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. If the Offeror does have a disclosure to make that is responsive to this section, the Offeror must use the appropriate form in Appendix G to make that disclosure and respond to this section. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the attestation included in Appendix G as its response to this section.	

4.3.2.6: Audited/Financial Statements and Pro Forma Financial Template (Marked): Pass/Fail

Response must include information as described below. The Pro Forma Financial Template (referenced as "Three (3) year financial pro forma") was linked in Appendix G of the RFQ. ***NOTE: For the Evaluator's convenience, due to the voluminous nature of these documents, they are in a separate PDF document for each proposal.***

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Audited financial statements for the contracting entity shall be provided for each of the last three (3) years, including, at a minimum: 1. Statement of income; 2. Balance sheet; 3. Statement of changes in financial position during the last three (3) years; 4. Statement of cash flow; 5. Auditors' reports; 6. Notes to financial statements; and 7. Summary of significant accounting policies. If the information requested above is not available, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support the explanation. Acceptance of the explanation provided is at the discretion of the Division. The Offeror must also submit the following: 1. Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the qualification; and, 2. Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror. The Division reserves the right to request any additional information to assure itself of an Offeror's financial status.	

[END OF 4.3.2, OWNERSHIP AND FINANCIAL INFORMATION]

4.3.3 Organization and Staffing

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state.

The Offeror is not allowed to list the name of staff in its response.

4.3.3.1 Organization (Marked): 10 Points Available

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The organization charts shall show: • Organization and staffing during each phase as described in the RFQ; • Full-time, part-time, and temporary status of all employees; and • Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared. For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."	Notes: • Offeror does not address additional staff to support implementation and operations of new services required in the contract • Offeror presented organizational chart that appears to share personnel across multiple lines of business • Offeror presented organizational chart that is lacking key personnel for various divisions • The organizational chart seems Incoherent and mismatched. Reporting staff, such as Pharmacy Director, not included with clinical staff.

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4.3.3.2 Job Description and Responsibilities of Key Positions (Marked): 20 Points Available

Response should use form in Appendix H for all positions listed below. The Offeror may not submit resumes or other information identifying current or prospective employees who are expected to fill the subject positions if the Offeror wins the contract.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
RFQ Instructions: The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract. The Offeror must use the appropriate form provided in Appendix H to respond to this request. **Positions required by Draft Contract Section 1.13 Administration Management, Facilities, and Resources provided for Evaluator's convenience.** **Draft Contract Section 1.13.1.1 Executive Positions** (refer to Draft Contract for full position description): 1. Chief Executive Officer 2. Chief Operating Officer 3. Chief Financial Officer 4. Medical Director 5. Perinatal Health Director 6. Behavioral Health Director 7. Chief Information Officer 8. Compliance Officer 9. Project Manager **Draft Contract Section 1.13.1.2 Administrative** Positions (refer to Draft Contract for full position description): 1. Provider Services Manager 2. Network/Contracting Manager 3. Member Services Manager	Notes: • Behavioral Health Director job description details collaboration with Medical Director, Perinatal Health Director, and Quality Manager to integrate mental and physical health initiatives • Lacks certification, licensing, and continuing education requirements for executive team • Lacks requirement of public health and/or informatics degree for Population Health Director

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
4. Quality Management Director 5. Care Management Director 6. Population Health Director 7. Utilization Management Coordinator 8. Grievance and Appeals Coordinator 9. Claims Administrator 10. Data and Analytics Manager 11. Clinical Pharmacist **1.13.2 Additional Staff Requirements** The Contractor shall also have the following staff located in Mississippi by the beginning of the term of the Contract: 1. A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division; 2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-Network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations; 3. Designated staff to be responsible for Marketing, Member communications, and/or public relations; 4. Sufficient support staff to conduct daily business in an orderly manner (to respond to this question, the Division expects the Offeror to make its own determination regarding what sufficient support staff would be needed for daily business based on its knowledge of its own needs for operation); 5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times; 6. All Care Managers; and 7. A designee or designees who can respond to issues involving systems and	

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract	

4.3.3.3 Administrative Requirements (Marked): 5 Points Available

Response must be provided using the form included in Appendix H of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror will verify and answer the following: 1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201- 1399, as required by the RFQ. 2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives. The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.	

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4.3.3.4 Staffing (Marked): 25 Points Available

Response is limited to 30 pages. In Amendment 4 (RFQ Q&A), Offerors were directed to assume a 125,000 Member enrollment in their CCO.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification. The Offeror will describe the following: 1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees. 2. Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees. 3. Describe staff who will be assigned to the quality management program and their qualifications. 4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a Member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers. 5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include whether the entity has successfully received accreditation for other state managed care programs, met required time	Notes: • Offeror incudes a diverse staff training program • Offeror undervalues the number of staff needed for member services (1:11,363) • Offeror does not include sufficient details regarding shared staff • Offeror states fully dedicated staff are also shared FTEs

Proposer: Magnolia Health Plan, Inc.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
frames to achieve accreditation, and any unsuccessful attempts. 6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications. 7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract. 8. Describe staff who will be responsible for subrogation and Third-Party Liability activities, including staffing levels and qualifications. 9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications. 10. Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared	

Proposer: Magnolia Health Plan, Inc.

4.3.3.5 Subcontractors (Marked): 20 Points Available

Response must include a narrative of no more than three (3) pages and applicable form(s) from Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services. For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.	Notes: • Performance Improvement Team comprised of all program areas reviews outcomes/work of subcontractors to ensure subcontractor performance

4.3.3.6 Economic Impact (Marked): 20 Points Available

Response must be provided using Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors. Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.	Notes: • Offeror provided actual economic impact dollar amounts, in addition to RFQ minimum required information, showing direct, indirect, and secondary impacts • Investment of $1 million for William Carey University to develop WCU College of Medicine Institute of Primary Care in Hattiesburg. • $15 or better hourly minimum wages • Offeror failed to provide a description of future investments other than $1 million William Carey investment

[END OF 4.3.3, ORGANIZATION AND STAFFING]

4.3.4 Management and Control

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

4.3.4.1 Day-to-Day Management (Marked): Pass/Fail

Response is limited to 20 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Program management approach; 2. Program control approach; 3. Manpower and time estimating methods; 4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable). 5. Management of performance standards, milestones, and/or deliverables; 6. Internal quality control monitoring; 7. Program status reporting, including examples of types of reports; and, 8. Approach to the Division's interaction with contract management staff.	

Proposer: Magnolia Health Plan, Inc.

4.3.4.2 Problem Management (Marked): Pass/Fail

Response is limited to 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Assessment of program risks and approach to managing them; 2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and 3. Approach to problem identification and resolution.	

Proposer: Magnolia Health Plan, Inc.

4.3.4.3 Backup Personnel Plan (Marked): Pass/Fail

Response is limited to 5 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff to allow for effective Division support	

4.3.4.4 Emergency Preparedness (Marked): Pass/Fail

Response is limited to 5 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of public enemy, occur during the life of the Contract.	

[END OF 4.3.4, MANAGEMENT AND CONTROL]

Proposer: Magnolia Health Plan, Inc.

Evaluation Team Consensus

Name	Signature	Date
Samantha Atkinson	Samantha Atkinson	7/15/2022 | 2:53:04 PM CDT
Dr. Catherine Brett	Catherine Brett	7/15/2022 | 3:32:28 PM CDT
Jennifer Grant	Jennifer Grant	7/15/2022 | 2:54:29 PM CDT
Keith Heartsill	Keith Heartsill	7/15/2022 | 2:59:29 PM CDT
Sharon Jones	Sharon Jones	7/15/2022 | 2:54:41 PM CDT
Evelyn Sampson	Evelyn Sampson	7/15/2022 | 2:58:19 PM CDT
Jennifer Wentworth	Jennifer Wentworth	7/15/2022 | 2:38:47 PM CDT

Consensus Scoring: Molina Healthcare of Mississippi, Inc. (Molina)

Offeror A

EVALUATION ROUND 1: TECHNICAL FACTORS – BLIND SCORING CONSENSUS TOOL

Summary of Point Distribution by Section

RFQ Question Set Topic	Related Contract Section(s)	Possible Points	Score
Methodology/Work Statement			
Executive Summary		Pass/Fail	Pass
Member Services and Benefits	Covered Services and Benefits	50	26
Provider Services and Network	Provider Services	50	30
Care Management	Care Management	50	26
Quality Management	Quality Management	50	25
Utilization Management	Quality Management, Throughout the Draft Contract	50	35
Information Technology	Throughout the Draft Contract	20	10
Subcontractual Relationships and Delegation	Subcontractual Relationships and Delegation	20	10
Financial and Data Reporting	Throughout the Draft Contract	15	6
Program Integrity	Fraud, Waste, and Abuse. Throughout the Draft Contract	15	9
Subrogation and Third-Party Liability	Third-Party Liability	10	6
Eligibility, Enrollment, and Disenrollment	Eligibility, Enrollment, and Disenrollment	10	6
		340	**189**
Innovation and Commitment			
Value-Based Purchasing	Quality Management	20	14
Patient-Centered Medical Homes	Provider Services	10	6
Social Determinants of Health	Throughout the Draft Contract	20	10
Value-Adds		10	6
Performance Improvement Projects	Quality Management	10	4
Health Literacy Campaigns	Quality Management	10	6
Telehealth	Covered Services and Benefits	10	4
Use of Technology	Member Services, throughout the Draft Contract	10	6
Potential Partnerships	Throughout the Draft Contract	10	5
		110	**61**
Total Points		**450**	**250**

Rating Guide

Rating for Applicable Section	50 Possible Points	20 Possible Points	15 Possible Points	10 Possible Points
Excellent Value (100%) Response exceeds expectations for many or all aspects of requirements and at least satisfies all aspects of requirements.	50	20	15	10
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	16	12	8
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	12	9	6
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	8	6	4
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	4	3	2
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0

Offeror A

Executive Summary (Pass/Fail)
Response is limited to 10 pages

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Did the Executive Summary include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of: a. Proposed work plan; b. Staff organizational structure; c. Key personnel; and, d. A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements? 2. Did the Executive Summary demonstrate the Offeror's understanding of the Division's vision for the Contract?	

Methodology Work Questionnaire (MWQ)

Directions from the RFQ:

Please respond to the questions. These statements and questions relate directly to the Major Program Elements described in Section 1.3.7 of this RFQ and related requirements set forth in Appendix A, Draft Contract. Please respond completely but succinctly. When specified, page limits indicate the maximum length of a response. Offerors are encouraged to respond in fewer pages if that is possible. Indicate "not applicable" to any item that is not relevant to the Offeror's qualification. Required documentation for specific answers will not be included as part of page limits and should be included in the body of the response, not as an attachment, unless otherwise indicated.

Unless specified, questions apply to both MississippiCAN and CHIP. If the Offeror's processes and procedures will differ by program for any requested item, make that distinction in the answer.

The Offeror should not construe a Contract section's listing as "related," to denote that the section listed is the only section in which the Question Set Topic is mentioned. The Offeror is responsible to reading and understanding all parts of the Appendix A, Draft Contract, and using that information to be responsive to the Question Sets.

The Offeror is reminded of the prohibition against including identifying information in any of answers. Where model documents are requested, the Offeror must remove all identifying information. Failure to comply with this rule may be basis for disqualification.

Unless specified, questions apply to both MississippiCAN and CHIP. If the processes for both are the same, note that. If the processes are different, make the distinction.

As noted above, the total number of points available for responses to this subsection is 340 points. Points available per element of this subsection are included in the element's title.

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available

Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each.

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Delivery of Covered Services 1. Children a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following: i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach	Notes: • Multiple Member outreach approaches (page 15 and Member satisfaction) • Mobile technology, including member app • Behavioral health will be managed directly by CCO and integrated with physical health care management • Noted several areas where they will coordinate efforts with other CCOs • Dental services are expanded for adults and all dental services managed by the CCO directly • Well defined NICU program/neonatal care management, and proposed Black Maternal Health and Infant Health PIP, obesity support • Well defined In-home Nurse Practitioner Program for newborns • UMMC School of Nursing to offer summer mobile healthcare services when school-based clinics are closed. • Response lacks specificity and actionable language • Does not describe how they will implement innovative approaches • Expectation is coordination of physical and behavioral health, but nurses are not utilized in this plan • Vague about how the Offeror anticipates the approach will improve health outcomes • Foster children – only talks about sending reports and not necessarily sharing real-time data or analytics with CPS to coordinate care

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, Immunizations, Well-Child visits, and any other services described in the CHIP State Health Plan. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children? 2. Behavioral Health Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
health/substance use disorder, including compliance with the SUPPORT Act. c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services? 3. Perinatal and Neonatal a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services. b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services. c. Describe any innovative methods that Offeror will use to augment its approach. d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services? 4. Chronic Conditions a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally. c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally. d. Describe any innovative methods that Offeror will use to augment its approach.	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions? 5. Foster Children a. Describe the Offeror's experience and/or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs. b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population. c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in its efforts to accurately identify and subsequently serve the medical needs of foster children and youth. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children? 6. Dental Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services? 7. Vision Services	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services. b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding vision services? 8. Additional Items a. State whether the Offeror will require any cost-sharing or copayments from MississippiCAN and/or CHIP Members. i. If yes, please describe what these cost-sharing/copayment requirements will be. b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP). c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section. d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services. **B. Member Services Call Center** 1. Describe the Offeror's Member services call center operations, including: a. Confirming that the location of the proposed operations will be within the State of Mississippi (provide a yes or no answer; do not include address); b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
standards are met (the Division retains the right to approve all call center standards); c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available; d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled; e. Training program for call center employees including cultural competency and Care Management; f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime; g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week; 2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities. **C. Member Handbook** 1. Describe how the Offeror's Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services. 2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System? **D. Website and Mobile Application** 1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application. 2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any).	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Member Education and Communication 1. Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use. 2. Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use. 3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including: a. An overview of the program, including accountabilities and proposed activities; b. The Offeror's rationale for selecting areas of focus; c. How the Offeror will ensure that materials are at a third (3rd) grade reading level; d. The language alternatives available to non-English speakers/readers; and, e. How Members who are visually and/or hearing impaired will be accommodated. 4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities. 5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe. 6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract. 7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104.	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available. 8. Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services. 9. Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division. **F. Member Satisfaction** 1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties. **G. Member Appeals** 1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract; b. Process for expedited review; c. Involvement of Members and their families in the Grievance and Appeal process; d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements;	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How Grievances are addressed prior to the filing of a Member appeal; and f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.	

[END OF SECTION]

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)

Response Limit: 45 pages, plus model provider contracts

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Provider Network 1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include: a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts; b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network; c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities; d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy; e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PMHCs' compliance with availability and scheduling appointment requirements and ensuring Members have	Notes: • Provider network recruiting includes identifying network gaps including out of network provider utilization • Detailed strategy of collaboration with providers to address Member medical conditions • Willing to collaborate with other CCOs to standardize language in the provider manual to assist providers • Dedicated care manager for each PRTF • Providers can access the shared care management IT platform, which coordinates member care, member data, services, and outcomes • Willingness to pay providers upon completion of credentialing rather than on or after the contract date • Lacks specificity for provider call center plan • Sample contracts allow for binding arbitration, which is not authorized by DOM

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and, f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network. g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy. 2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities. 3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. 4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete. 5. Submit templates of the Offeror's standard Provider contracts. 6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including: a. System used to identify and notify Members affected by Provider loss;	

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
b. Automated systems and membership supports used to assist affected Members with Provider transitions; c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition; and, d. Approach to cover membership needs with existing network resources following terminations. 7. Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care. 8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to: a. Issue IRS 1099 forms, b. Meet all federal and Division reporting requirements, and c. Cross-reference to state and federal identification numbers to identify and report excluded Providers. **B. Provider Services Call Center** 1. Describe the Offeror's Provider services call center operations including: a. Hours of operation; b. Describe how the Offeror will ensure call center employees will have cultural competency; c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards);	

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
d. Training program for call center employees including local and statewide cultural competency; and, e. A description of any plans to use electronic communication to respond to Provider inquiries. 2. Describe how the Offeror will assess the quality and efficiency of the Call Center. **C. Provider Education and Communication** 1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system. 2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a Member for behavioral health/substance use disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems. 3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections. 4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics. 5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.	

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties. 7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services. 8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances: a. Perinatal; b. Behavioral Health; c. Substance Use Disorder; d. Chronic Conditions; and e. Foster Children. **D. Collaboration with Providers** 1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity. 2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care. 3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members.	

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Provider Payment 1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis. 2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Offeror's claims processing system. 3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s). **F. Provider Grievances and Appeals** 1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract; b. Process for elevating Provider Grievances; and, c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.	

[END OF SECTION]

MWQ 4.2.2.3: Care Management (50 Total Possible Points)

Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages.

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Care Management Proposal 1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response: a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach; b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities; c. How the Offeror will ensure that Care Management is a tool to address health equity concerns; d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and, e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high). **B. Stratification and Assignment** 1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking	Notes: • Unique plan to notify providers when members in their panel are admitted to the hospital • Details a unique readmission risk score process • Details an extensive and thorough transition of care program; Offeror demonstrates an understanding of the transition of care process • Innovative staffing choices • Lack of comprehensive, statewide programs • Lacks overall detail and actionable steps • Inadequate management of low-risk populations with limited resources provided and extended re-evaluation timelines • Inadequate detail of performance measure; lacks specific action steps to achieve success • No mention of coordination with statewide HIEs • Insufficient details of an overall communication strategy to DOM • Did not include medication information in hypotheticals • Insufficient details in HRS and CHA (e.g., medication information for care management purposes) • A diverse data lake will be used for pulling information for risk stratification (Exhibit 2)

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
answers, and how answers will be used for stratification of Members based on acuity levels and Care Management. 2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management. 3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment with the Offeror in order to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment. 4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools. 5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA. **C. Care Management Services** 1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
notify Members and/or Providers when follow-up is due. Address the following issues in the response: a. Facilitation and monitoring of Member compliance with treatment plans; b. Partnerships of community-based partnerships and other state agencies; and c. Coordination with other Providers. 2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in identifying and gaining access to community resources that may provide services not covered. 3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response: a. The Offeror's role and the PCP's/PCMH's role in this process; b. Examples of information that the Offeror will provide to Providers; c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and, d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation. e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties. **D. Transition of Care** 1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process. 2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including: a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services; b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff; c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and, d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and network pharmacist to assure continuation of needed therapy. 3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation.	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Staff 1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following: a. Education and training required for Care Managers; b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers; c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases; d. And overview of the Offeror's continuing education and training plan for its Care Managers; and e. Expected wages to be paid to Care Managers (hourly/salary and what amounts). **F. Hypotheticals** 1. Describe the Offeror's approach to providing Care Management in the following scenarios: a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months; b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable; c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
needs was admitted last night to a local inpatient facility after presenting with an asthma attack; d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week; and, e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a Member.	

[END OF SECTION]

MWQ 4.2.2.4: Quality Management (50 Total Possible Points)

Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to 10 pages.

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Quality Management Program 1. Describe the Offeror's proposed quality management program, including: a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable; b. The program's lines of accountability; c. Process for selecting areas of focus; d. Process for using evidence-based practices; e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy; f. Use of data to design, implement and evaluate the effectiveness of the program; g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and h. How the Offeror will address health access and equity in its quality management program 2. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages). **B. Clinical Guidelines and Compliance** 1. Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines.	Notes: • Proposes a joint CCO task force and will take lead in standardization of materials • Lacks overall actionable steps to drive quality outcomes • Lacks specificity on how they would use advanced data and analytics • Lack of substance on how to address SDOH strategies • Insufficient detail in work plan for QM plan • Appears to be more directed at quality assurance that quality management • Insufficient details of an overall communication strategy to DOM

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 3. Describe the Offeror's proposed process for compliance with the SUPPORT Act. 4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 5. Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered. 6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers. 7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for precluding payment to Providers and reporting to the Division via encounter data in accordance with 42 C.F.R. § 438.3. 8. Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions. **C. Quality Measurement** 1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract. a. Describe the type of build necessary to create these types of reports.	

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidences efficacy of programs.	

[END OF SECTION]

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)

Response Limit: 30 pages

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to utilization management, including: a. A description of the utilization management program; b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures; 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 used to develop utilization review criteria; e. Expected Prior Authorization clinical criteria by program area; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates; g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization; h. The Offeror's approach to reducing the number of Prior Authorizations required; i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and	Notes: • Details a streamlining of UM processes • Will provide UM dashboard that contains potential errors/delays in real-time • Use of innovative strategies to limit prior authorization requirements • Supports provider transparency with a very detailed provider communication process • Communication strategies with PCPs to offer additional care management based on member needs • Will work with hospitals to assist with the Corrective Action Plans for Quality Improvement Payment Program (QIPP) Potentially Preventable Hospital Returns (PPHR)

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
j. Processes to ensure consistent application of criteria by individual clinical reviewers. **B. Methods** 1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy. 2. Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program. 3. Describe how the Offeror will identify and address trends in over- and under-utilization. 4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members. 5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.	

[END OF SECTION]

MQW 4.2.2.6: Information Technology (20 Total Possible Points)

Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages.

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Claims Processing 1. Describe the Offeror's claims processing system including: a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program. 2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion. 3. Describe the Offeror's claims processing operations including: a. The claims processing systems that will support this program; b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program; c. The Offeror's process for dealing with discovered compliance issues through an expedited process; d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an	Notes: • Strong description of collaboration with DOM, CCOs and providers in the event of a disaster • Unclear what is meant by underpayment adjudication outside the core claims processing system. (Page 299, #3, D) • Lacks specific details relevant to IT infrastructure

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
example of how the Offeror has addressed these deficiencies or variances. **B. Technological Systems** 1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System. 2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies. 3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate. 4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies. **C. Innovation** 1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members. 2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network. 3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division. **D. Continuity of Operations** 1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including a. Employee training; b. Essential business functions and responsible key employees;	

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; d. Communication with staff and suppliers when normal systems are unavailable; e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components; f. Security and privacy requirements; and g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.	

[END OF SECTION]

MQW 4.2.2.7: Subcontractual Relationships and Delegation (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Services to be Subcontracted 1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor. 2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor. **B. Subcontractor Oversight** 1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will: a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor; b. Ensure receipt and reconciliation of all required data including encounter data; c. Ensure appropriate utilization of health care services; d. Ensure delivery of administrative and health care services meets all standards required by this RFQ; e. Ensure adherence to required Grievance policies and procedures; and, f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how	Notes: • Offeror indicates NET services will be available 24/7/365 for non-emergent transportation. • Will conduct pre-delegation audits to ensure subcontractor can meet requirements • Lacks reconciliation of estimated subcontractual costs in MLR reports to actual expenses (page 327) • Did not include TPL subcontractor in listing

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
the Offeror has addressed a deficiency or contractual variance with a Subcontractor. g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division. h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.	

[END OF SECTION]

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)
Response Limit: 20 pages

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Financial Reporting 1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c). 2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized. **B. Data Reporting** 1. Encounter Data a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan. 2. Health Information System Data a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes,	Notes: • Annual Encounter Data Completeness Plan lacks specificity of key components to be included in the plan • Exhibit on page 333 does not include subcontractor claims

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
integrates, validates, and reports data including but not limited to the following areas: i. Utilization, ii. Claims, Grievances and Appeals, iii. Disenrollment (for other than loss of Medicaid eligibility), iv. Member Characteristics, v. Provider Characteristics, vi. Care Management Utilization, vii. Clinical Data, and viii. Population Health.	

[END OF SECTION]

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)
Response Limit: 20 Pages

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Fraud, Waste, and Abuse 1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including: a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable; b. Process for acting upon suspected cases of fraud, waste and abuse; c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers; d. Process for interacting with the Division, including the Office of Program Integrity; and, e. Other components of the Offeror's fraud, waste, and abuse program. **B. Claim Denials** 1. Describe the Offeror's proposed Denials Review and Reporting program, including: a. A description of the Offeror's Denials Management program; b. A summary/listing of the Offeror's denials criteria/protocol; c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria; d. The Offeror's reconsideration process as it relates to claims denials; and	Notes: • Exceeds the minimum number of investigators required • Commitment to additional work with OPI to further investigate and recover payments • Commitment to proactively review fraud, waste, and abuse trends and patterns and report to DOM • Will send monthly reports of investigations and their status to DOM

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. The Offeror's process for notifying and educating providers of claims denials. **C. National Correct Coding Initiative (MississippiCAN)** 1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.	

[END OF SECTION]

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)
Response Limit: 10 pages

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including: a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division; b. Process for retrospective post payment recoveries of health-related insurance; c. Process for adjudicating claims involving third party coverage; d. Process for identifying, recouping, and releasing claims; e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP; f. Data analytics and informatics used to support the process; and, g. Process for providing supplemental third-party data and files to the Division. h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes. 2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best practices" to ensure that they are optimizing the TPL recoveries on behalf of the Division? a. If yes, describe the Offeror's process.	Notes: • In addition to the TPL vendor, the staff providing TPL supplemental information is MS-based, and can verify dates and accuracy of TPL resources • Process for reconciling third-party liability payments will include monthly reports on an annual basis, which will render more timely results

Offeror A

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
B. Effectiveness 1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective. 2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.	

[END OF SECTION]

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)

Response Limit: 15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C(1)(e) (optional). Each appendix is limited to five (5) pages each.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. File Management 1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses. 2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including: a. Process for outreach and engagement of Members; b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program; and c. The Offeror's draft disenrollment survey. **B. Assignment of Members to a Primary Care Physician** 1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to: a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection; b. Track data to confirm that every Member is assigned; c. Inform PCPs/PCMHs of new Members within the required time frames; and d. Confirm that PCPs/PCMHs received the list of assigned Members.	Notes: • Offeror appears to have an adequate understanding and methods responsive to this RFQ section

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members. 3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment. 4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs. 5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments. 6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments. **C. Member Information** 1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following: a. Language alternatives that will be available; b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract;	

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses; and d. Process for following up with Members whose information packets or identification cards are returned. e. Offeror may choose to include sample member materials in excess of the page limit.	

[END OF SECTION]

[END OF METHODOLOGY WORK QUESTIONNAIRE]

Innovation and Commitment (I&C)

From the RFQ:

Central to the Division's strategy for the next contract cycle are a number of new and/or improved initiatives it plans to implement. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans). The Offeror should also be attentive to standards and expectations described in Appendix A, Draft Contract, in designing its proposals.

After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.

As noted above, the total number of points available for responses to this subsection is 110 points. Points available per element of this subsection are included in the element's title.

I&C 4.2.3.1: Value-Based Purchasing (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a strategy to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. The program must describe how the CCOs will work collaboratively with the Division's subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. The Offeror must produce a Value-Based Purchasing proposal for the Division, considering the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Includes an approach that explains "one-size fits all" will not work for DOM's needs • Understands assessment of providers for VBP readiness and does not assume that all providers are at the same level of readiness for VBP participation • Willing to engage all stakeholders in development • Offeror will be ready to go Year 1 with a VBP model that could cover a majority of Medicaid members • Limited details regarding communication strategy with DOM

[END OF SECTION]

Offeror A

I&C 4.2.3.2: Patient-Centered Medical Home (PCMH) (10 Total Possible Points)
Response Limited: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle. PCMHs should be made available to all medium- and high-risk Members. The system is discussed more in Section 6.2.5, Patient-Centered Medical Homes, of Appendix A, Draft Contract. The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through with PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • As an example of a milestone that can be achieved, the PCMH will receive bonuses to become NCQA-certified data aggregators. Requirements include EHR interoperability and HIE participation in alignment with VBP programs. • Practices will work to achieve quality measures in 3 priority quality areas decided by and adopted through the cross-section PCMH steering committee to ensure metrics are meaningful and aligned with State goals. • PCMH proposed plans are stated, but do not demonstrate a good understanding of PCMH and their purpose

[END OF SECTION]

I&C 4.2.3.3: Social Determinants of Health (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions: 1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data. 2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations? 3. What approaches will the Offeror take to address these challenges? 4. How will the Offeror address Health Equity through its SDOH programs? 5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)? Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches. **The Social Determinants of Health: Staffing table does not count against the Offeror's response limit to this question.**	Notes: • States willingness to commit direct donations to non-profit CBOs • States multiple assessment tools for nurses to evaluate for SDOH • States utilization of a dedicated SDOH manager • Insufficient detail on addressing SDOH needs of members

[END OF SECTION]

I&C 4.2.3.4: Value Added Benefits (10 Total Possible Points) (No page limit)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of Division-curated Value-Adds are included in Appendix E. The Offeror may choose from the Division's list of value-adds, describe some of their own, both, or elect not to include value-adds in its proposal. If no Value-Adds are included, the Offeror will receive a score of zero for this section. If offering any Value-Add in its response, the Offeror should make summary proposals of any and all Value- utilizing the following charts provided in Appendix E: • Value-Added Benefit: Summary Chart • Value-Added Benefit: Staffing (if applicable) If the Offeror is not including Value-Adds with its proposal, the Offeror should use the form provided in Appendix E as its answer to this request.	Notes: • Will provide breast pumps after delivery in a very timely manner • Missed opportunities to make a meaningful impact

[END OF SECTION]

I&C 4.2.3.5: Performance Improvement Projects (10 Total Possible Points)
Response Limit: 4 PIP Proposals pages: 2 for CHIP and 2 for MSCAN + staffing pages (if applicable)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, both for the purposes of scalability and measurement. This is discussed more in Section 8, Quality Management, of Appendix A, Draft Contract. After selection, Contractors will submit their PIPs to the Division for standardization, and Contractors will be required to cross-collaborate on at least one PIP. The Offeror should include with its proposal summaries of its first year of proposed Performance Improvement Projects for MississippiCAN and CHIP. To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs utilizing the following charts provided in Appendix E: • Performance Improvement Project: Summary Chart • Performance Improvement Project: Staffing (if applicable)	Notes: • Strong details of evaluation process (e.g., monthly review of PIPs and adaption if not meeting DOM's goals) • Included details regarding collaborative PIP with other CCOs • Overall, proposed PIPs are too broad, with too many interventions/activities, and too many measures to accurately track a successful PIP. • Poor correlation between proposed metrics and interventions • Insufficient frequency in communication strategy to DOM

[END OF SECTION]

I&C 4.2.3.6: Health Literacy Campaigns (10 Total Possible Points)
Response is limited to 4 campaigns + staffing pages if applicable

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The Division plans to coordinate a common strategy among Contractors in order to best amplify important health education to Members. More details can be found in Section 8.10.8, Health Literacy Campaigns, of Appendix A, Draft Contract. To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns utilizing the following charts provided in Appendix E: • Health Literacy Campaign: Summary Chart • Health Literacy Campaign: Staffing (if applicable)	Notes: • Lactation Education Literacy Campaign is strong • Use of Weight Watchers is very appropriate for Healthy, Active Lifestyle Campaign • The campaigns are too broad and too varied for effective member impact

[END OF SECTION]

I&C 4.2.3.1: Telehealth (10 Total Possible Points)
Response Limit: 8 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals form Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.	Notes: • Use of national telehealth providers has the potential to not comply with DOM policy regarding provider enrollment with MS Medicaid

[END OF SECTION]

I&C 4.2.3.8: Use of Technology (10 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs: 1. Data gathering and analysis 2. Efficacy of initiatives and programs 3. Transparency	Notes: • Customized Executive Dashboard with high-level information and the ability to drill down to more specific information • Innovative customizable partner portal

[END OF SECTION]

I&C 4.2.3.9: Potential Partnerships (10 Total Possible Points)

Response Limit: 8 partnerships total: 4 Potential Partnerships, 4 Potential Care Management Partnerships

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. This requirement is discussed through Appendix A, Draft Contract. The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners. The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs. This requirement is discussed in detail in Section 7, Care Management, of Appendix E. The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners. The Offeror may not duplicate potential partners in answering either part of this request. The Offeror should not include in its answer any information regarding any current or prior relationship with a proposed partner. The Offeror's explanation for choosing the Offeror should describe how work with the proposed partner directly connects to requirements of Appendix A, Draft Contract, and this RFQ, with no reference to any other contract or lines of business of the Offeror.	Notes: • Partnership to utilize a mobile nursing program is innovative • Limited timeframe for one or more partnerships that will occur for one year only and not the lifetime of this contract • Funding amounts of the financial commitment for some partnerships appear to be too low to allow for an effective program • Missed opportunity by not including the MS Dept of Education due to a large EPSDT population

[END OF SECTION]

[END OF INNOVATION & COMMITMENT]

Evaluation Team Consensus

Name	Signature and Date
Samantha Atkinson	Samantha Atkinson 5/23/2022 | 11:42:09 AM CDT
Dr. Catherine Brett	Catherine Brett 5/26/2022 | 2:19:36 PM CDT
Jennifer Grant	Jennifer Grant 5/20/2022 | 4:12:58 PM CDT
Keith Heartsill	Keith Heartsill 5/23/2022 | 9:41:48 AM CDT
Sharon Jones	Sharon Jones 5/19/2022 | 7:37:44 PM CDT
Evelyn Sampson	Evelyn Sampson 5/20/2022 | 2:18:02 PM CDT
Jennifer Wentworth	Jennifer Wentworth 5/20/2022 | 8:56:35 AM CDT

Management Factors Evaluation
Division of Medicaid Coordinated Care Organization RFQ
RFQ # 20211210
RFx # 3150003991

Proposer: Molina Healthcare of Mississippi, Inc.

EVALUATION ROUND 2: MANAGEMENT FACTORS – MARKED/INFORMED CONSENSUS SCORE

Summary of Point Distribution by Section

RFQ Question Set Topic	Points Available	Score
Corporate Background and Experience		
Corporate Background: Biographical Information	20	12
Corporate Background: Corporate Resources	50	37
Corporate Experience	30	21
	100	**70**
Ownership and Financial Disclosure Information		
Information to be Disclosed	Pass/Fail	Pass
When and to Whom Information Will Be Disclosed	Pass/Fail	Pass
Information Related to Business Transactions	Pass/Fail	Pass
Change of Ownership	Pass/Fail	Pass
Disclosure of Identity of Any Person Convicted of a Criminal Offense	Pass/Fail	Pass
Audited Financial Statements	Pass/Fail	Pass
Organization and Staffing		
Organization	10	5
Job Descriptions and Responsibilities	20	10
Administrative Requirements	5	4
Staffing	25	16
Subcontractors	20	12
Economic Impact	20	9
	100	**56**
Management and Control		
Day-to-Day Management	Pass/Fail	Pass
Problem Management	Pass/Fail	Pass
Backup Personnel Plan	Pass/Fail	Pass
Emergency Preparedness Plan	Pass/Fail	Pass
Total Points	**200**	**126**

Proposer: Molina Healthcare of Mississippi, Inc.

Rating Guide

Rating for Applicable Section	50 Points	30 Points	25 Points	20 Points	10 Points	5 Points
Excellent Value (100%) Response exceeds expectations on all aspects of requirements and at least satisfies all aspects of requirements.	50	30	25	20	10	5
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	24	20	16	8	4
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	18	15	12	6	3
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	12	10	8	4	2
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	6	5	4	2	1
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0	0	0

4.3.1 Corporate Background and Experience (100 points available)

From the RFQ:

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, and details of corporate experience relevant to the proposed Contract including all current or recent MississippiCAN, CHIP, or related projects.

4.3.1.1 Corporate Background

This section has two subparts:

- 4.3.1.1.1 Biographical Information
- 4.3.1.1.2 Corporate Resources

4.3.1.1.1: Corporate Background: Biographical Information (Marked): 20 Points Available

Response must be provided using the form included in Appendix F of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
See Appendix F, form entitled "Biographical Information"	

Proposer: Molina Healthcare of Mississippi, Inc.

4.3.1.1.2: Corporate Background: Corporate Resources (Marked): 50 Points Available

Response is limited to 40 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror may answer the following questions using narratives, charts, and lists as appropriate. • Describe the Offeror's Computer and Technological Resources • Describe the Offeror's Current Products and Services • Describe the Offeror's Intangible Assets • Describe any unique and/or innovative resources in which the Offeror specializes • Describe additional resources of the Offeror	Notes: • Offeror demonstrates diversity and integration in care management • Offeror included strong intangible assets • Offeror includes strong description of products and services • Offeror's IT diagram provides a well-defined flow of support and delivery of services • Offeror commits to a definitive amount of $3M investment in Mississippi that clearly ties to needed healthcare improvements • Offeror demonstrates understanding of the needs of the population • Offeror includes good description of how DOM will be able to access data • Offeror allows for automated EHR access for 278 PA transactions • Offeror lacks detail on disaster recovery and redundancy of data backup • Offeror lacks detail regarding innovation outside of RFQ/Contract requirements

4.3.1.2: Corporate Experience (Marked): 30 Points Available

Response must be provided using the form included in Appendix F of the RFQ (form entitled "Corporate Experience: Current and/or Recent Client.")
If the Offeror does not have the requested experience, then they must provide a narrative explanation not to exceed three (3) pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000. [Clarification about 400,000: The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.] If the information requested above is not available, the Offeror must provide a narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.	Notes: • Offeror provided concise, detailed, specific descriptions of work performed

[END OF 4.3.1 CORPORATE BACKGROUND AND EXPERIENCE]

4.3.2 Ownership and Financial Disclosure Information

From the RFQ:

For many of the requirements of this section, the Offeror should utilize forms provided in Appendix G: Ownership and Financial Disclosure Information. If a form has been provided in this RFQ to respond to a requirement, no other response will be accepted.

4.3.2.1: Information to Be Disclosed (Marked): Pass/Fail

Response must be provided using the forms included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(b), the Offeror shall make certain disclosures. The Offeror must use the forms provided in Appendix G to provide this information. Titles of Forms that should be used: • Section 1: Ownership Interest and/or Managing Control Identification Information – subsections of that form: • Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification • Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control • Section 1(c): Familial Relationships • Section 2: Disclosure of Subcontractor Information • Section 3: Other Disclosing Entities	

4.3.2.2: When and to Whom Information Will be Disclosed (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times: 1. Upon the Contractor submitting a qualification in accordance with the State's procurement process; 2. Annually, including upon the execution, renewal, and extension of the contract with the State; and, 3. Within thirty-five (35) days after any change in ownership of the Contractor. In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency. The Offeror must use the appropriate form in Appendix G as its response to this section.	

4.3.2.3: Information Related to Business Transactions (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must use the appropriate form in Appendix G to provide this information. In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about: 1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and, 2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request. If the Offeror does not have information responsive to this request, then they should sign the attestation provided in Appendix G. If the Offeror does have information responsive to this request, they it should provide that information with the form(s) entitled Business Transactions with Subcontractors and Significant Business Transactions in Appendix G, as applicable.	

4.3.2.4: Change of Ownership (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A change of ownership of the Offeror includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Offeror. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. The Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor. Should the Contractor undergo a change of direct ownership, the Contractor must notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract. If the Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to the Division in writing within sixty (60) calendar days of the end of each quarter. If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract. **If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the appropriate attestation included in Appendix G as its response to this section. [emphasis added for Evaluator's convenience.]**	

Proposer: Molina Healthcare of Mississippi, Inc.

4.3.2.5: Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 106 (a), the Contractor shall disclose to the Division the identity of any person who: 1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and, 2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. If the Offeror does have a disclosure to make that is responsive to this section, the Offeror must use the appropriate form in Appendix G to make that disclosure and respond to this section. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the attestation included in Appendix G as its response to this section.	

4.3.2.6: Audited/Financial Statements and Pro Forma Financial Template (Marked): Pass/Fail

Response must include information as described below. The Pro Forma Financial Template (referenced as "Three (3) year financial pro forma") was linked in Appendix G of the RFQ. ***NOTE: For the Evaluator's convenience, due to the voluminous nature of these documents, they are in a separate PDF document for each proposal.***

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Audited financial statements for the contracting entity shall be provided for each of the last three (3) years, including, at a minimum: 1. Statement of income; 2. Balance sheet; 3. Statement of changes in financial position during the last three (3) years; 4. Statement of cash flow; 5. Auditors' reports; 6. Notes to financial statements; and 7. Summary of significant accounting policies. If the information requested above is not available, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support the explanation. Acceptance of the explanation provided is at the discretion of the Division. The Offeror must also submit the following: 1. Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the qualification; and, 2. Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror. The Division reserves the right to request any additional information to assure itself of an Offeror's financial status.	

[END OF 4.3.2, OWNERSHIP AND FINANCIAL INFORMATION]

4.3.3 Organization and Staffing

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state.

The Offeror is not allowed to list the name of staff in its response.

4.3.3.1 Organization (Marked): 10 Points Available

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The organization charts shall show: • Organization and staffing during each phase as described in the RFQ; • Full-time, part-time, and temporary status of all employees; and • Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared. For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."	Notes: • Offeror included three phases of the organizational chart: Implementation, Operations, and Turnover • Offeror undervalued the number of staff needed to perform requirements of this contract • The organizational chart seems incoherent - mismatched reporting staff. Disjointed CHIP structure –CHIP Program Director reports to Compliance Officer, and CHIP Program Manager reports to Quality Management Director

4.3.3.2 Job Description and Responsibilities of Key Positions (Marked): 20 Points Available

Response should use form in Appendix H for all positions listed below. The Offeror may not submit resumes or other information identifying current or prospective employees who are expected to fill the subject positions if the Offeror wins the contract.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
RFQ Instructions: The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract. The Offeror must use the appropriate form provided in Appendix H to respond to this request. **Positions required by Draft Contract Section 1.13 Administration Management, Facilities, and Resources provided for Evaluator's convenience.** **Draft Contract Section 1.13.1.1 Executive Positions** (refer to Draft Contract for full position description): 1. Chief Executive Officer 2. Chief Operating Officer 3. Chief Financial Officer 4. Medical Director 5. Perinatal Health Director 6. Behavioral Health Director 7. Chief Information Officer 8. Compliance Officer 9. Project Manager **Draft Contract Section 1.13.1.2 Administrative** Positions (refer to Draft Contract for full position description): 1. Provider Services Manager 2. Network/Contracting Manager 3. Member Services Manager	Notes: • Lack of requirements for specific roles, specifically minimum educational requirements, and continuing education requirements, for key personnel and clinical and professional staff

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
4. Quality Management Director 5. Care Management Director 6. Population Health Director 7. Utilization Management Coordinator 8. Grievance and Appeals Coordinator 9. Claims Administrator 10. Data and Analytics Manager 11. Clinical Pharmacist **1.13.2 Additional Staff Requirements** The Contractor shall also have the following staff located in Mississippi by the beginning of the term of the Contract: 1. A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division; 2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-Network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations; 3. Designated staff to be responsible for Marketing, Member communications, and/or public relations; 4. Sufficient support staff to conduct daily business in an orderly manner (to respond to this question, the Division expects the Offeror to make its own determination regarding what sufficient support staff would be needed for daily business based on its knowledge of its own needs for operation); 5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times; 6. All Care Managers; and 7. A designee or designees who can respond to issues involving systems and	

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract	

Proposer: Molina Healthcare of Mississippi, Inc.

4.3.3.3 Administrative Requirements (Marked): 5 Points Available

Response must be provided using the form included in Appendix H of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror will verify and answer the following: 1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201- 1399, as required by the RFQ. 2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives. The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.	

Proposer: Molina Healthcare of Mississippi, Inc.

4.3.3.4 Staffing (Marked): 25 Points Available

Response is limited to 30 pages. In Amendment 4 (RFQ Q&A), Offerors were directed to assume a 125,000 Member enrollment in their CCO.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*

The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification.
 	
The Offeror will describe the following:
1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees.
2. Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees.
3. Describe staff who will be assigned to the quality management program and their qualifications.
4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a Member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers.
5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include whether the entity has successfully received accreditation for other state managed care programs, met required time
	Notes:
	• Offeror's broad solutions relevant to the MS Medicaid population including:
	  ○ Offeror includes a good ratio of call center representatives to members (1:5K)
	  ○ Offeror includes additional targeted staff specific to the needs of the MS population (e.g., addiction, pulmonology, etc.)
	• Offeror lacks detail regarding the local encounter team and reconciliation process

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
frames to achieve accreditation, and any unsuccessful attempts. 6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications. 7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract. 8. Describe staff who will be responsible for subrogation and Third-Party Liability activities, including staffing levels and qualifications. 9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications. 10. Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared	

4.3.3.5 Subcontractors (Marked): 20 Points Available

Response must include a narrative of no more than three (3) pages and applicable form(s) from Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services. For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.	

4.3.3.6 Economic Impact (Marked): 20 Points Available

Response must be provided using Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors. Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.	Notes: • Mentioned the use of an economic impact analysis tool, but did not summarize or explain the actual economic impact to Mississippi (last bullet, page 343) • Did not quantify the points provided in the key elements in this section (page 343) • Offeror failed to provide a description of future investments other than committing $3 million to Mississippi community and Provider support programs through the MolinaCares Accord, with a Contract Year 1 commitment of $750,000 • Minimum hourly wages for many staff is $11.09 ($23,059.58 annualized)

[END OF 4.3.3, ORGANIZATION AND STAFFING]

4.3.4 Management and Control

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

4.3.4.1 Day-to-Day Management (Marked): Pass/Fail

Response is limited to 20 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Program management approach; 2. Program control approach; 3. Manpower and time estimating methods; 4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable). 5. Management of performance standards, milestones, and/or deliverables; 6. Internal quality control monitoring; 7. Program status reporting, including examples of types of reports; and, 8. Approach to the Division's interaction with contract management staff.	

Proposer: Molina Healthcare of Mississippi, Inc.

4.3.4.2 Problem Management (Marked): Pass/Fail

Response is limited to 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Assessment of program risks and approach to managing them; 2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and 3. Approach to problem identification and resolution.	

Proposer: Molina Healthcare of Mississippi, Inc.

4.3.4.3 Backup Personnel Plan (Marked): Pass/Fail

Response is limited to 5 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff to allow for effective Division support	

4.3.4.4 Emergency Preparedness (Marked): Pass/Fail

Response is limited to 5 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of public enemy, occur during the life of the Contract.	

[END OF 4.3.4, MANAGEMENT AND CONTROL]

Proposer: Molina Healthcare of Mississippi, Inc.

Evaluation Team Consensus

Name	Signature	Date
Samantha Atkinson	Samantha Atkinson	7/15/2022 | 2:54:40 PM CDT
Dr. Catherine Brett	Catherine Brett	7/15/2022 | 3:31:57 PM CDT
Jennifer Grant	Jennifer Grant	7/15/2022 | 2:53:42 PM CDT
Keith Heartsill	Keith Heartsill	7/15/2022 | 3:02:49 PM CDT
Sharon Jones	Sharon Jones	7/15/2022 | 2:55:26 PM CDT
Evelyn Sampson	Evelyn Sampson	7/15/2022 | 2:57:57 PM CDT
Jennifer Wentworth	Jennifer Wentworth	7/15/2022 | 2:42:03 PM CDT

Consensus Scoring:

Mississippi True d/b/a True Care (True Care)

Offeror C

EVALUATION ROUND 1: TECHNICAL FACTORS – BLIND SCORING CONSENSUS

Summary of Point Distribution by Section

RFQ Question Set Topic	Related Contract Section(s)	Possible Points	Score
Methodology/Work Statement			
Executive Summary		Pass/Fail	Pass
Member Services and Benefits	Covered Services and Benefits	50	45
Provider Services and Network	Provider Services	50	35
Care Management	Care Management	50	46
Quality Management	Quality Management	50	45
Utilization Management	Quality Management, Throughout the Draft Contract	50	40
Information Technology	Throughout the Draft Contract	20	16
Subcontractual Relationships and Delegation	Subcontractual Relationships and Delegation	20	11
Financial and Data Reporting	Throughout the Draft Contract	15	10
Program Integrity	Fraud, Waste, and Abuse. Throughout the Draft Contract	15	11
Subrogation and Third-Party Liability	Third-Party Liability	10	6
Eligibility, Enrollment, and Disenrollment	Eligibility, Enrollment, and Disenrollment	10	7
		340	**272**
Innovation and Commitment			
Value-Based Purchasing	Quality Management	20	14
Patient-Centered Medical Homes	Provider Services	10	8
Social Determinants of Health	Throughout the Draft Contract	20	13
Value-Adds		10	9
Performance Improvement Projects	Quality Management	10	5
Health Literacy Campaigns	Quality Management	10	6
Telehealth	Covered Services and Benefits	10	8
Use of Technology	Member Services, throughout the Draft Contract	10	7
Potential Partnerships	Throughout the Draft Contract	10	6
		110	**76**
Total Points		**450**	**348**

Offeror C

Rating Guide

Rating for Applicable Section	50 Possible Points	20 Possible Points	15 Possible Points	10 Possible Points
Excellent Value (100%) Response exceeds expectations for many or all aspects of requirements and at least satisfies all aspects of requirements.	50	20	15	10
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	16	12	8
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	12	9	6
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	8	6	4
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	4	3	2
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0

Offeror C

Executive Summary (Pass/Fail)
Response is limited to 10 pages

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Did the Executive Summary include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of: • Proposed work plan; • Staff organizational structure; • Key personnel; and, • A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements? 2. Did the Executive Summary demonstrate the Offeror's understanding of the Division's vision for the Contract?	

Offeror C

Methodology Work Questionnaire (MWQ)

Directions from the RFQ:

Please respond to the questions. These statements and questions relate directly to the Major Program Elements described in Section 1.3.7 of this RFQ and related requirements set forth in Appendix A, Draft Contract. Please respond completely but succinctly. When specified, page limits indicate the maximum length of a response. Offerors are encouraged to respond in fewer pages if that is possible. Indicate "not applicable" to any item that is not relevant to the Offeror's qualification. Required documentation for specific answers will not be included as part of page limits and should be included in the body of the response, not as an attachment, unless otherwise indicated.

Unless specified, questions apply to both MississippiCAN and CHIP. If the Offeror's processes and procedures will differ by program for any requested item, make that distinction in the answer.

The Offeror should not construe a Contract section's listing as "related," to denote that the section listed is the only section in which the Question Set Topic is mentioned. The Offeror is responsible to reading and understanding all parts of the Appendix A, Draft Contract, and using that information to be responsive to the Question Sets.

The Offeror is reminded of the prohibition against including identifying information in any of answers. Where model documents are requested, the Offeror must remove all identifying information. Failure to comply with this rule may be basis for disqualification.

Unless specified, questions apply to both MississippiCAN and CHIP. If the processes for both are the same, note that. If the processes are different, make the distinction.

As noted above, the total number of points available for responses to this subsection is 340 points. Points available per element of this subsection are included in the element's title.

Offeror C

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available

Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each.

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Delivery of Covered Services 1. Children a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following: i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, Immunizations, Well-Child visits, and any other services described in the CHIP State Health Plan. Include the following: 1. An overview of related policies, procedures, and processes	Notes: • Offeror's proposal provides exceptionally detailed explanations of their proposed programs • Robust foster care program with highest level of care management services and dedicated foster care clinic • Mobile app is well developed for the Medicaid population • NET available for job interviews, trips to pharmacy, and other social needs • Includes day care provider and schools as stakeholders • System will have an EPSDT dashboard • New Mom program will provide information 5 days after birth regarding EPSDT • Real-time, bidirectional data exchange • Will manage behavioral health program directly • Will waive co-pay for CHIP population • Strong education program for PCPs on behavioral health resources • Specific emphasis on tracking CHIP utilization and gaps • Dedicated Member Advisory Committee • Dedicated Provider Advisory Committee • Understands the needs of the MS Medicaid program and the MS environment

Offeror C

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children? 2. Behavioral Health Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral health/substance use disorder, including compliance with the SUPPORT Act. c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services? 3. Perinatal and Neonatal	

Offeror C

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services. b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services. c. Describe any innovative methods that Offeror will use to augment its approach. d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services? 4. Chronic Conditions a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally. c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions? 5. Foster Children a. Describe the Offeror's experience and/or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs. b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population. c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
its efforts to accurately identify and subsequently serve the medical needs of foster children and youth. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children? 6. Dental Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services? 7. Vision Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services. b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding vision services? 8. Additional Items a. State whether the Offeror will required any cost-sharing or copayments from MississippiCAN and/or CHIP Members. i. If yes, please describe what these cost-sharing/copayment requirements will be. b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP).	

Offeror C

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section. d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services. **B. Member Services Call Center** 1. Describe the Offeror's Member services call center operations, including: a. Confirming that the location of the proposed operations will be within the State of Mississippi (provide a yes or no answer; do not include address); b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure standards are met (the Division retains the right to approve all call center standards); c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available; d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled; e. Training program for call center employees including cultural competency and Care Management; f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime; g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week; 2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities. **C. Member Handbook** 1. Describe how the Offeror's Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services. 2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System?	

Offeror C

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
D. Website and Mobile Application 1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application. 2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any). **E. Member Education and Communication** 1. Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use. 2. Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use. 3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including: a. An overview of the program, including accountabilities and proposed activities; b. The Offeror's rationale for selecting areas of focus; c. How the Offeror will ensure that materials are at a third (3rd) grade reading level; d. The language alternatives available to non-English speakers/readers; and, e. How Members who are visually and/or hearing impaired will be accommodated. 4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities. 5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe. 6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract.	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104. Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available. 8. Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services. 9. Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division. **F. Member Satisfaction** 1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties. **G. Member Appeals** 1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract; b. Process for expedited review; c. Involvement of Members and their families in the Grievance and Appeal process; d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements; e. How Grievances are addressed prior to the filing of a Member appeal; and f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.	

[END OF SECTION]

Offeror C

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)

Response Limit: 45 pages, plus model provider contracts

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Provider Network 1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include: a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts; b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network; c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities; d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy; e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PMHCs' compliance with availability and scheduling appointment requirements and ensuring Members have access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and, f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network.	Notes: • Claims payment time exceeds DOM expectations. The Offeror states 99% of Behavioral Health claims processed within 5 days and all other claims with 3-day average speed, and first pass accuracy rate greater than 99%. • Dedicated Provider Resolution Unit (PRU) is responsible for resolving complex provider issues that require additional internal escalation. • Will use a daily dashboard to monitor enrollment timeframes and take action to ensure prompt provider enrollment and contracting • Proposal provided case study to address large provider system loss, which affects network adequacy • Providers will track performance through one of the comprehensive suite of provider tools and data analytics, including Provider Performance Dashboard and clinical Practice registry. • Pay-for-Reporting includes incentives for HEDIS measures that directly ties to DOM's quality initiatives • Use of patient-centered dental medical home is an incentive program for dentists to increase preventive dental care • Clear, intentional description of incentives to reduce provider administrative burdens related to medical service authorizations • Plans to resolve provider network gaps for members with immediate needs, in Table 4.2.2.2_B addresses some of DOM concerns for member access to care

Offeror C

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy. 2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities. 3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. 4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete. 5. Submit templates of the Offeror's standard Provider contracts. 6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including: a. System used to identify and notify Members affected by Provider loss; b. Automated systems and membership supports used to assist affected Members with Provider transitions; c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition; and, d. Approach to cover membership needs with existing network resources following terminations. 7. Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care. 8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to:	• Limited detail for the CCO FFS claims processing plan (review, reconciliation), even though proposal does address subcontractor claims processing

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
a. Issue IRS 1099 forms, b. Meet all federal and Division reporting requirements, and c. Cross-reference to state and federal identification numbers to identify and report excluded Providers. **B. Provider Services Call Center** 1. Describe the Offeror's Provider services call center operations including: a. Hours of operation; b. Describe how the Offeror will ensure call center employees will have cultural competency; c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards); d. Training program for call center employees including local and statewide cultural competency; and, e. A description of any plans to use electronic communication to respond to Provider inquiries. 2. Describe how the Offeror will assess the quality and efficiency of the Call Center. **C. Provider Education and Communication** 1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system. 2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a Member for behavioral health/substance use	

Offeror C

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems. 3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections. 4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics. 5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training. 6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties. 7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services. 8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances: a. Perinatal; b. Behavioral Health; c. Substance Use Disorder; d. Chronic Conditions; and e. Foster Children. **D. Collaboration with Providers** 1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity.	

Offeror C

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care. 3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members. **E. Provider Payment** 1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis. 2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Offeror's claims processing system. 3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s). **F. Provider Grievances and Appeals** 1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract; b. Process for elevating Provider Grievances; and, c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.	

[END OF SECTION]

Offeror C

MWQ 4.2.2.3: Care Management (50 Total Possible Points)

Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages.

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Care Management Proposal 1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response: a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach; b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities; c. How the Offeror will ensure that Care Management is a tool to address health equity concerns; d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and, e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high). **B. Stratification and Assignment** 1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking answers, and how answers will be used for stratification of Members based on acuity levels and Care Management. 2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial	Notes: • Overall CM plan appears to be comprehensive and extensive; goes above and beyond what is asked in the RFQ • Details use of statewide HIEs • Proposes to lead an effort to standardize HRS with other CCOs • Appears to have a well thought out and comprehensive engagement model for members. o Diverse avenues to reach non-responsive members identified as needing CM o Will engage members at non-traditional access points (e.g., Walmart, Dollar General, grocery stores) • Strong details around Risk Screening and stratification: o Unique array of predictive modeling tools o Use of state HIE and FQHC data for risk stratification o Use of non-traditional points of access for performing HRS (e.g., Walmart, Dollar General, grocery stores) o Extensive details of criteria used for risk stratification o Automatic enrollment of Foster Care members in highest/complex risk category • Details unique enhanced pharmacy services to close care gaps • Extensive engagement with providers o Care gaps available for review in real time in provider portal o Details how care managers and providers reps will directly reach out to notify providers of members' needed services • Will cover all pregnancy related visits, even if out of network

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management. 3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment with the Offeror in order to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment. 4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools. 5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA. **C. Care Management Services** 1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will notify Members and/or Providers when follow-up is due. Address the following issues in the response: a. Facilitation and monitoring of Member compliance with treatment plans; b. Partnerships of community-based partnerships and other state agencies; and c. Coordination with other Providers. 2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in	• Care plan in place for those leaving incarceration and transitioning back to the community • Detailed plan of communication of care management goals, results, and secondary analysis to DOM

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
identifying and gaining access to community resources that may provide services not covered. 3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response: a. The Offeror's role and the PCP's/PCMH's role in this process; b. Examples of information that the Offeror will provide to Providers; c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and, d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation. e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties. **D. Transition of Care** 1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process. 2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including: a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services;	

Offeror C

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff; c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and, d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and network pharmacist to assure continuation of needed therapy. 3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation. **E. Staff** 1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following: a. Education and training required for Care Managers; b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers; c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases; d. And overview of the Offeror's continuing education and training plan for its Care Managers; and e. Expected wages to be paid to Care Managers (hourly/salary and what amounts). **F. Hypotheticals** 1. Describe the Offeror's approach to providing Care Management in the following scenarios: a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months;	

Offeror C

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable; c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health needs was admitted last night to a local inpatient facility after presenting with an asthma attack; d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week; and, e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a Member.	

[END OF SECTION]

Offeror C

MWQ 4.2.2.4: Quality Management (50 Total Possible Points)

Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to 10 pages.

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Quality Management Program 1. Describe the Offeror's proposed quality management program, including: a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable; b. The program's lines of accountability; c. Process for selecting areas of focus; d. Process for using evidence-based practices; e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy; f. Use of data to design, implement and evaluate the effectiveness of the program; g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and h. How the Offeror will address health access and equity in its quality management program 2. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages). **B. Clinical Guidelines and Compliance** 1. Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines. 2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 3. Describe the Offeror's proposed process for compliance with the SUPPORT Act.	Notes: • Proposes partnership with other CCOs to lead the standardization of clinical practice guidelines • Exhibits a depth of understanding of the importance of quality management in managed care for the holistic needs of the agency and stakeholders • Details use of Quadruple Aim (as opposed to Triple Aim) • Unique feature of provider portal to include a controlled substances report to providers as well as 360 evaluation of controlled substance prescribing habits of provider • Defines and elaborates on the diverse data analytics tools and predictive modeling available via the data analytics tool table • Strong quality management improvement plan evaluation process • Unique description of population health and HEDIS dashboards • Quality Management and Improvement Committee only meets quarterly, without mention of meeting timelines for other committees/subcommittees

Offeror C

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 5. Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered. 6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers. 7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for precluding payment to Providers and reporting to the Division via encounter data in accordance with 42 C.F.R. § 438.3. 8. Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions. **C. Quality Measurement** 1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract. a. Describe the type of build necessary to create these types of reports. 2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidences efficacy of programs.	

[END OF SECTION]

Offeror C

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)

Response Limit: 30 pages

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to utilization management, including: a. A description of the utilization management program; b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures; 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 used to develop utilization review criteria; e. Expected Prior Authorization clinical criteria by program area; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates; g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization; h. The Offeror's approach to reducing the number of Prior Authorizations required; i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and j. Processes to ensure consistent application of criteria by individual clinical reviewers. **B. Methods** 1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its	Notes: • Will use NP telehealth platform to decrease ER utilization • Plans to collaborate with hospitals and providers regarding discharge planning • Will embed health workers with providers to assist in discharge and home planning • Aligns VBP with UM and QM along with Quality Improvement Payment Program (QIPP) Potentially Preventable Hospital Returns (PPHR) to reduce hospital readmissions (page 287) • Will Include multiple stakeholders in developing UM criteria • Demonstrates use of an automatic algorithm-based authorization process for providers for certain items/services via the UM portal • Will designate regional QM/UM staff to work directly with providers to conduct root cause analysis and implement targeted interventions to reduce avoidable hospital utilizations • Plans to operate an integrated UM program • The Offeror intends to utilize practitioner led in-home assessments as part of their underutilization monitoring of well-child visits in MS. (page 287)

Offeror C

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy. 2. Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program. 3. Describe how the Offeror will identify and address trends in over- and under-utilization. 4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members. 5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.	

[END OF SECTION]

Offeror C

MQW 4.2.2.6: Information Technology (20 Total Possible Points)

Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages.

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Claims Processing 1. Describe the Offeror's claims processing system including: a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program. 2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion. 3. Describe the Offeror's claims processing operations including: a. The claims processing systems that will support this program; b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program; c. The Offeror's process for dealing with discovered compliance issues through an expedited process; d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an example of how the Offeror has addressed these deficiencies or variances. **B. Technological Systems** 1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System.	Notes: • Innovative real time claims payments for providers serving rural members • IT Infrastructure and processes seem well established; as shown by the strong Recovery Time Objective and Recovery Point Objective • Processing 98% of clean claims within five days and 100% of claims within thirty days exceeds contractual requirements • Prospective & Retrospective Auditing and Controls section was strong • Triage of previously impacted claims within twenty-five days appears to be a highly effective process • Emergency response and continuity plan included a dedicated data liaison

Offeror C

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies. 3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate. 4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies. **C. Innovation** 1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members. 2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network. 3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division. **D. Continuity of Operations** 1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including a. Employee training; b. Essential business functions and responsible key employees; c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;	

Offeror C

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
d. Communication with staff and suppliers when normal systems are unavailable; e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components; f. Security and privacy requirements; and g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.	

[END OF SECTION]

Offeror C

MQW 4.2.2.7: Subcontractual Relationships and Delegation (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Services to be Subcontracted 1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor. 2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor. **B. Subcontractor Oversight** 1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will: a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor; b. Ensure receipt and reconciliation of all required data including encounter data; c. Ensure appropriate utilization of health care services; d. Ensure delivery of administrative and health care services meets all standards required by this RFQ; e. Ensure adherence to required Grievance policies and procedures; and, f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how	Notes: • Provides listing of additional subcontractors • Will utilize a dedicated Subcontract Coordinator and Compliance Committee for oversight • Will not delegate grievances and appeals process • Provides thorough details about the amount and types of subcontractor audits • Did not include TPL subcontractor in listing

Offeror C

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
the Offeror has addressed a deficiency or contractual variance with a Subcontractor. g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division. h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.	

[END OF SECTION]

Offeror C

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)
Response Limit: 20 pages

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Financial Reporting 1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c). 2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized. **B. Data Reporting** 1. Encounter Data a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan. 2. Health Information System Data a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes, integrates, validates, and reports data including but not limited to the following areas: i. Utilization, ii. Claims, Grievances and Appeals,	Notes: • Offeror provides a very detailed description of the overall compilation and reporting of the MLR • Encounters Reporting Chart clearly denotes subcontractor data, and provides analysis Offeror requires from subcontractors for error checking • Historical encounters excellence shows positive outcomes for accuracy and completeness • Encounters dashboards will allow DOM to track where encounters are v. bi-monthly reconciliations and crosswalks that DOM presents to the CCOs

Offeror C

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
iii. Disenrollment (for other than loss of Medicaid eligibility), iv. Member Characteristics, v. Provider Characteristics, vi. Care Management Utilization, vii. Clinical Data, and viii. Population Health.	

[END OF SECTION]

Offeror C

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)

Response Limit: 20 Pages

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Fraud, Waste, and Abuse 1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including: a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable; b. Process for acting upon suspected cases of fraud, waste and abuse; c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers; d. Process for interacting with the Division, including the Office of Program Integrity; and, e. Other components of the Offeror's fraud, waste, and abuse program. **B. Claim Denials** 1. Describe the Offeror's proposed Denials Review and Reporting program, including: a. A description of the Offeror's Denials Management program; b. A summary/listing of the Offeror's denials criteria/protocol; c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria; d. The Offeror's reconsideration process as it relates to claims denials; and e. The Offeror's process for notifying and educating providers of claims denials.	Notes: • Provided detailed and specific examples of tools/methodology for conducting operations • Detailed information about the standards and best practices to be used for Program Integrity • Detailed chart and substantive explanations of the fraud detection (both proactive and reactive) systems to be employed • Specific commitment to direct and immediate collaboration with regulators/law enforcement • Provided significant and meaningful detail about their plans for subcontractor oversight • Committed to provide a dedicated Medicaid Director who is also a Certified Coder for Program Integrity operations • Detailed specific and strong internal control and external oversight • Proposal chart presented historical claims denials rates that are above the expected range established by the Division

Offeror C

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
C. National Correct Coding Initiative (MississippiCAN) 1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.	

[END OF SECTION]

Offeror C

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)
Response Limit: 10 pages

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including: a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division; b. Process for retrospective post payment recoveries of health-related insurance; c. Process for adjudicating claims involving third party coverage; d. Process for identifying, recouping, and releasing claims; e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP; f. Data analytics and informatics used to support the process; and, g. Process for providing supplemental third-party data and files to the Division. h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes. 2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best practices" to ensure that they are optimizing the TPL recoveries on behalf of the Division? a. If yes, describe the Offeror's process. **B. Effectiveness** 1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective.	Notes: • Proposal states that Offeror has consistently adjusted 50% of incorrectly paid claims due to TPL within 30 days of original payment and 70% within 60 days. This timeliness allows providers to identify TPL issues earlier and adjust their records without significant time delays. • This section lacks specificity and actionable language

Offeror C

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.	

[END OF SECTION]

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)

Response Limit: 15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C(1)(e) (optional). Each appendix is limited to five (5) pages each.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. File Management 1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses. 2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including: a. Process for outreach and engagement of Members; b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program; and c. The Offeror's draft disenrollment survey. **B. Assignment of Members to a Primary Care Physician** 1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to: a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection; b. Track data to confirm that every Member is assigned; c. Inform PCPs/PCMHs of new Members within the required time frames; and d. Confirm that PCPs/PCMHs received the list of assigned Members.	Notes: • Programmatically identifies discrepancies between DOM 834 enrollment file, and internal enrollment data, and member premium financial system. Data mismatches captured in exceptions tool, including missing member records, demographic information. Through member onboarding process, members informed that they may use the communication channel of their choice (call, email, text, live chat). This provides members with multiple modes of communication (see Figure 4.2.2.11_B). • Proposal states that to resolve member barriers to using assigned PCP/PCMH and keep appointments, Offeror will develop broad initiatives, such as United Way 211, that help connect members to local resources like food, housing, and childcare. • Offeror did not provide subcontractor details regarding timely processing of the member eligibility file, as subcontractors are required to meet the same requirements as the CCO.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members. 3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment. 4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs. 5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments. 6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments. **C. Member Information** 1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following: a. Language alternatives that will be available; b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract; c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses; and	

Offeror C

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
d. Process for following up with Members whose information packets or identification cards are returned. e. Offeror may choose to include sample member materials in excess of the page limit.	

[END OF SECTION]

[END OF METHODOLOGY WORK QUESTIONNAIRE]

Offeror C

Innovation and Commitment (I&C)

From the RFQ:

Central to the Division's strategy for the next contract cycle are a number of new and/or improved initiatives it plans to implement. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans). The Offeror should also be attentive to standards and expectations described in Appendix A, Draft Contract, in designing its proposals.

After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.

As noted above, the total number of points available for responses to this subsection is 110 points. Points available per element of this subsection are included in the element's title.

Offeror C

I&C 4.2.3.1: Value-Based Purchasing (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a strategy to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. The program must describe how the CCOs will work collaboratively with the Division's subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. The Offeror must produce a Value-Based Purchasing proposal for the Division, considering the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Includes a well thought out VBP plan that will grow providers in tiers over the course of the contract • Outlines four VBP levels that are clearly defined and tied to quality • The "Path to Value Plan" is well planned and defined • Will commit to helping providers (financially and offering resources) become NCQA accredited PCMHs • Details the connection with VBPs and episodes of care

[END OF SECTION]

Offeror C

I&C 4.2.3.2: Patient-Centered Medical Home (PCMH) (10 Total Possible Points)
Response Limited: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle. PCMHs should be made available to all medium- and high-risk Members. The system is discussed more in Section 6.2.5, Patient-Centered Medical Homes, of Appendix A, Draft Contract. The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through with PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Well defined and expansive approach to PCMHs that integrates with other approaches defined in the proposal • Offeror is committed to assisting providers to become PCMHs by pledging $500,000 to support them in their effort as well as providing them with wraparound support, training, real-time actionable data, and financial models to overcome transformation challenges. Offeror Will actively review data to identify and recruit PCMHs in the most appropriate areas, specifically in rural areas • Integrates pharmacy into the PCMH model. Offeror's internal pharmacy program supports PCMH members through the medication therapy management program in which licensed pharmacist conducts an annual review of member medications to reduce risk of negative drug interaction or unnecessary medications • Direct linkage of PCMHs to care managers, integration of care management with PCMH model, PCMH care management training, PCMH access to evidence-based tools and decision-making supports, and PCMH member referrals to care management • Access to real-time data through connection to a statewide HIE and interoperability with providers' EHRs will improve coordination of care, resulting in improved health outcomes and decreased avoidable high-cost utilization. Use of identified competencies for intentional staffing as referenced in Figure 4.2.3.2_B.

[END OF SECTION]

Offeror C

I&C 4.2.3.3: Social Determinants of Health (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions: 1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data. 2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations? 3. What approaches will the Offeror take to address these challenges? 4. How will the Offeror address Health Equity through its SDOH programs? 5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)? Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches. **The Social Determinants of Health: Staffing table does not count against the Offeror's response limit to this question.**	Notes: • States willingness to go above 0.5% PMPM requirement for SDOH efforts • States care managers will take responsibility of SDOH challenges • Clearly and thoroughly identifies how SDOH challenges will be addressed • Unique details of an incentive for community partners • Unique details of focus placed on opportunities that will most directly impact the Members

[END OF SECTION]

Offeror C

I&C 4.2.3.4: Value Added Benefits (10 Total Possible Points) (No page limit)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of Division-curated Value-Adds are included in Appendix E. The Offeror may choose from the Division's list of value-adds, describe some of their own, both, or elect not to include value-adds in its proposal. If no Value-Adds are included, the Offeror will receive a score of zero for this section. If offering any Value-Add in its response, the Offeror should make summary proposals of any and all Value- utilizing the following charts provided in Appendix E: • Value-Added Benefit: Summary Chart • Value-Added Benefit: Staffing (if applicable) If the Offeror is not including Value-Adds with its proposal, the Offeror should use the form provided in Appendix E as its answer to this request.	Notes: • Will offer a Comprehensive Wound care program • Will conduct at-home postpartum visits • Offers enhanced benefits for pregnant women • Will provide a home scale for all NICU babies • Will cover respite care for juveniles • Extensive NET benefits to address SDOH challenges • Will offer enhanced adult dental services • Will utilize a Dedicated EPSDT Coordinator • Will allow SDOH assistance funds up to $500 per member for various needs • Funding amounts allocated may be inadequate except for NET, enhanced adult dental, and vision

[END OF SECTION]

Offeror C

I&C 4.2.3.5: Performance Improvement Projects (10 Total Possible Points)

Response Limit: 4 PIP Proposals pages: 2 for CHIP and 2 for MSCAN + staffing pages (if applicable)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, both for the purposes of scalability and measurement. This is discussed more in Section 8, Quality Management, of Appendix A, Draft Contract. After selection, Contractors will submit their PIPs to the Division for standardization, and Contractors will be required to cross-collaborate on at least one PIP. The Offeror should include with its proposal summaries of its first year of proposed Performance Improvement Projects for MississippiCAN and CHIP. To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs utilizing the following charts provided in Appendix E: • Performance Improvement Project: Summary Chart • Performance Improvement Project: Staffing (if applicable)	Notes: • Extensive and thorough description of PIPs. • Use of SMART Goals for all PIPs. • Strong details on attaining goals and partners to be utilized • Response fails to address requirements of a collaborative PIP • Interventions for some PIPs too broad, will need a narrowing of scope to be a successful PIP • Insufficient details of an overall communication strategy to DOM

[END OF SECTION]

Offeror C

I&C 4.2.3.6: Health Literacy Campaigns (10 Total Possible Points)
Response is limited to 4 campaigns + staffing pages if applicable

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The Division plans to coordinate a common strategy among Contractors in order to best amplify important health education to Members. More details can be found in Section 8.10.8, Health Literacy Campaigns, of Appendix A, Draft Contract. To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns utilizing the following charts provided in Appendix E: • Health Literacy Campaign: Summary Chart • Health Literacy Campaign: Staffing (if applicable)	Notes: • There is HOPE and There is HELP: This campaign works with adolescents and their parents • Health Literacy topics do not appear to be innovative

[END OF SECTION]

Offeror C

I&C 4.2.3.7: Telehealth (10 Total Possible Points)
Response Limit: 8 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals form Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.	Notes: • Exceptional detail regarding use of pandemic telehealth post-utilization data to inform and develop a robust telehealth policy • Will provide technical assistance to providers • Will build a telehealth provider network and offer a learning collaborative • Will partner with C Spire • Will utilize the 24-hour nurse line as a method to help Members schedule telehealth appointments • Offers NP interventions for targeted telehealth services 8AM to 8PM daily • Offers alternative telehealth services such as information exchange with providers who do not offer telehealth services

[END OF SECTION]

Offeror C

I&C 4.2.3.8: Use of Technology (10 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs: 1. Data gathering and analysis 2. Efficacy of initiatives and programs 3. Transparency	Notes: • Innovative Transparency: dashboards, data connectivity, timely reporting • Thorough explanation of the use of the HIE • Strong data analytics explanations and good dashboard examples • Dedicated Data Liaison • Innovative VBP Dashboard

[END OF SECTION]

Offeror C

I&C 4.2.3.9: Potential Partnerships (10 Total Possible Points)

Response Limit: 8 partnerships total: 4 Potential Partnerships, 4 Potential Care Management Partnerships

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. This requirement is discussed through Appendix A, Draft Contract. The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners. The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs. This requirement is discussed in detail in Section 7, Care Management, of Appendix E. The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners. The Offeror may not duplicate potential partners in answering either part of this request. The Offeror should not include in its answer any information regarding any current or prior relationship with a proposed partner. The Offeror's explanation for choosing the Offeror should describe how work with the proposed partner directly connects to requirements of Appendix A, Draft Contract, and this RFQ, with no reference to any other contract or lines of business of the Offeror.	Notes: • Partnerships align with DOM needs • Missed opportunity by not including the MS Dept of Education due to a large EPSDT population

[END OF SECTION]

[END OF INNOVATION & COMMITMENT]

Offeror C

Evaluation Team Consensus

Name	Signature and Date
Samantha Atkinson	Samantha Atkinson 5/23/2022 | 11:52:34 AM CDT
Dr. Catherine Brett	Catherine Brett 5/26/2022 | 2:21:38 PM CDT
Jennifer Grant	Jennifer Grant 5/20/2022 | 4:10:20 PM CDT
Keith Heartsill	Keith Heartsill 5/23/2022 | 10:09:39 AM CDT
Sharon Jones	Sharon Jones 5/25/2022 | 4:33:55 PM CDT
Evelyn Sampson	Evelyn Sampson 5/20/2022 | 2:16:44 PM CDT
Jennifer Wentworth	Jennifer Wentworth 5/20/2022 | 8:57:35 AM CDT

Management Factors Evaluation
Division of Medicaid Coordinated Care Organization RFQ
RFQ # 20211210
RFx # 3150003991

Proposer: TrueCare

EVALUATION ROUND 2: MANAGEMENT FACTORS – MARKED/INFORMED CONSENSUS SCORE

Summary of Point Distribution by Section

RFQ Question Set Topic	Points Available	Score
Corporate Background and Experience		
Corporate Background: Biographical Information	20	18
Corporate Background: Corporate Resources	50	30
Corporate Experience	30	18
	100	**66**
Ownership and Financial Disclosure Information		
Information to be Disclosed	Pass/Fail	Pass
When and to Whom Information Will Be Disclosed	Pass/Fail	Pass
Information Related to Business Transactions	Pass/Fail	Pass
Change of Ownership	Pass/Fail	Pass
Disclosure of Identity of Any Person Convicted of a Criminal Offense	Pass/Fail	Pass
Audited Financial Statements	Pass/Fail	Pass
Organization and Staffing		
Organization	10	6
Job Descriptions and Responsibilities	20	11
Administrative Requirements	5	3
Staffing	25	13
Subcontractors	20	12
Economic Impact	20	12
	100	**57**
Management and Control		
Day-to-Day Management	Pass/Fail	Pass
Problem Management	Pass/Fail	Pass
Backup Personnel Plan	Pass/Fail	Pass
Emergency Preparedness Plan	Pass/Fail	Pass
Total Points	**200**	**123**

Proposer: TrueCare

Rating Guide

Rating for Applicable Section	50 Points	30 Points	25 Points	20 Points	10 Points	5 Points
Excellent Value (100%) Response exceeds expectations on all aspects of requirements and at least satisfies all aspects of requirements.	50	30	25	20	10	5
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	24	20	16	8	4
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	18	15	12	6	3
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	12	10	8	4	2
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	6	5	4	2	1
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0	0	0

4.3.1 Corporate Background and Experience (100 points available)

From the RFQ:

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, and details of corporate experience relevant to the proposed Contract including all current or recent MississippiCAN, CHIP, or related projects.

4.3.1.1 Corporate Background

This section has two subparts:

- 4.3.1.1.1 Biographical Information
- 4.3.1.1.2 Corporate Resources

4.3.1.1.1: Corporate Background: Biographical Information (Marked): 20 Points Available

Response must be provided using the form included in Appendix F of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
See Appendix F, form entitled "Biographical Information"	Notes: • Positive investment in MS staffing • Offeror plans to hire 1,600 full-time employees

Proposer: TrueCare

4.3.1.1.2: Corporate Background: Corporate Resources (Marked): 50 Points Available

Response is limited to 40 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror may answer the following questions using narratives, charts, and lists as appropriate. • Describe the Offeror's Computer and Technological Resources • Describe the Offeror's Current Products and Services • Describe the Offeror's Intangible Assets • Describe any unique and/or innovative resources in which the Offeror specializes • Describe additional resources of the Offeror	Notes: • Offeror included all the value-adds DOM sought • Offeror provides a strong, well-organized listing of resources • Offeror demonstrates a strong commitment to community partners • Offeror allows for real-time claims payment • Offeror will allow foster care to have access to care plans • Offeror demonstrates strong employee benefit and retainment plans • Offeror includes an innovative incarceration reintegration plan • Offeror lacks detail regarding innovation outside of RFQ/Contract requirements • Offeror lacks detail and substance when describing execution of partnerships with CBOs • Offeror included multiple projects that are limited to certain areas, which is a missed opportunity for member healthcare impact

4.3.1.2: Corporate Experience (Marked): 30 Points Available

Response must be provided using the form included in Appendix F of the RFQ (form entitled "Corporate Experience: Current and/or Recent Client.")
If the Offeror does not have the requested experience, then they must provide a narrative explanation not to exceed three (3) pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000. [Clarification about 400,000: The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.] If the information requested above is not available, the Offeror must provide a narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.	

[END OF 4.3.1 CORPORATE BACKGROUND AND EXPERIENCE]

4.3.2 Ownership and Financial Disclosure Information

From the RFQ:

For many of the requirements of this section, the Offeror should utilize forms provided in Appendix G: Ownership and Financial Disclosure Information. If a form has been provided in this RFQ to respond to a requirement, no other response will be accepted.

4.3.2.1: Information to Be Disclosed (Marked): Pass/Fail

Response must be provided using the forms included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(b), the Offeror shall make certain disclosures. The Offeror must use the forms provided in Appendix G to provide this information. Titles of Forms that should be used: • Section 1: Ownership Interest and/or Managing Control Identification Information – subsections of that form: • Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification • Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control • Section 1(c): Familial Relationships • Section 2: Disclosure of Subcontractor Information • Section 3: Other Disclosing Entities	

4.3.2.2: When and to Whom Information Will be Disclosed (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times: 1. Upon the Contractor submitting a qualification in accordance with the State's procurement process; 2. Annually, including upon the execution, renewal, and extension of the contract with the State; and, 3. Within thirty-five (35) days after any change in ownership of the Contractor. In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency. The Offeror must use the appropriate form in Appendix G as its response to this section.	

4.3.2.3: Information Related to Business Transactions (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must use the appropriate form in Appendix G to provide this information. In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about: 1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and, 2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request. If the Offeror does not have information responsive to this request, then they should sign the attestation provided in Appendix G. If the Offeror does have information responsive to this request, they it should provide that information with the form(s) entitled Business Transactions with Subcontractors and Significant Business Transactions in Appendix G, as applicable.	

4.3.2.4: Change of Ownership (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A change of ownership of the Offeror includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Offeror. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. The Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor. Should the Contractor undergo a change of direct ownership, the Contractor must notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract. If the Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to the Division in writing within sixty (60) calendar days of the end of each quarter. If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract. **If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the appropriate attestation included in Appendix G as its response to this section. [emphasis added for Evaluator's convenience.]**	

Proposer: TrueCare

4.3.2.5: Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 106 (a), the Contractor shall disclose to the Division the identity of any person who: 1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and, 2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. If the Offeror does have a disclosure to make that is responsive to this section, the Offeror must use the appropriate form in Appendix G to make that disclosure and respond to this section. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the attestation included in Appendix G as its response to this section.	

4.3.2.6: Audited/Financial Statements and Pro Forma Financial Template (Marked): Pass/Fail

Response must include information as described below. The Pro Forma Financial Template (referenced as "Three (3) year financial pro forma") was linked in Appendix G of the RFQ. ***NOTE: For the Evaluator's convenience, due to the voluminous nature of these documents, they are in a separate PDF document for each proposal.***

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Audited financial statements for the contracting entity shall be provided for each of the last three (3) years, including, at a minimum: 1. Statement of income; 2. Balance sheet; 3. Statement of changes in financial position during the last three (3) years; 4. Statement of cash flow; 5. Auditors' reports; 6. Notes to financial statements; and 7. Summary of significant accounting policies. If the information requested above is not available, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support the explanation. Acceptance of the explanation provided is at the discretion of the Division. The Offeror must also submit the following: 1. Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the qualification; and, 2. Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror. The Division reserves the right to request any additional information to assure itself of an Offeror's financial status.	

[END OF 4.3.2, OWNERSHIP AND FINANCIAL INFORMATION]

4.3.3 Organization and Staffing

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state.

The Offeror is not allowed to list the name of staff in its response.

4.3.3.1 Organization (Marked): 10 Points Available

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The organization charts shall show: • Organization and staffing during each phase as described in the RFQ; • Full-time, part-time, and temporary status of all employees; and • Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared. For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."	Notes: • Offeror compiled a New Market Implementation Playbook based on best practices from previous state implementations, which is very practical and innovative. • Offeror presented a cohesive and thoughtful listing of staff in multiple organizational charts • Offeror stated that over 1,600 wholly dedicated positions will be in Mississippi, but it is difficult to determine the placement of these staff members in the organizational chart • Unclear how Offeror plans to train 1,600 newly-hired staff members by the Operational period of the Contract

4.3.3.2 Job Description and Responsibilities of Key Positions (Marked): 20 Points Available

Response should use form in Appendix H for all positions listed below. The Offeror may not submit resumes or other information identifying current or prospective employees who are expected to fill the subject positions if the Offeror wins the contract.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
RFQ Instructions: The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract. The Offeror must use the appropriate form provided in Appendix H to respond to this request. **Positions required by Draft Contract Section 1.13 Administration Management, Facilities, and Resources provided for Evaluator's convenience.** **Draft Contract Section 1.13.1.1 Executive Positions** (refer to Draft Contract for full position description): 1. Chief Executive Officer 2. Chief Operating Officer 3. Chief Financial Officer 4. Medical Director 5. Perinatal Health Director 6. Behavioral Health Director 7. Chief Information Officer 8. Compliance Officer 9. Project Manager **Draft Contract Section 1.13.1.2 Administrative** Positions (refer to Draft Contract for full position description): 1. Provider Services Manager 2. Network/Contracting Manager 3. Member Services Manager	Notes: • Concise hiring table 4.3.3.2_A • Education requirements for some staff are confusing. Managers do not require a BA while their direct reports require a BA. • Lack of requirements for specific roles, specifically minimum educational requirements, and continuing education requirements, for key personnel and clinical and professional staff • Offeror did not specifically address requirements for Network Contracting Manager

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
4. Quality Management Director 5. Care Management Director 6. Population Health Director 7. Utilization Management Coordinator 8. Grievance and Appeals Coordinator 9. Claims Administrator 10. Data and Analytics Manager 11. Clinical Pharmacist **1.13.2 Additional Staff Requirements** The Contractor shall also have the following staff located in Mississippi by the beginning of the term of the Contract: 1. A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division; 2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-Network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations; 3. Designated staff to be responsible for Marketing, Member communications, and/or public relations; 4. Sufficient support staff to conduct daily business in an orderly manner (to respond to this question, the Division expects the Offeror to make its own determination regarding what sufficient support staff would be needed for daily business based on its knowledge of its own needs for operation); 5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times; 6. All Care Managers; and 7. A designee or designees who can respond to issues involving systems and	

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract	

Proposer: TrueCare

4.3.3.3 Administrative Requirements (Marked): 5 Points Available

Response must be provided using the form included in Appendix H of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror will verify and answer the following: 1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201- 1399, as required by the RFQ. 2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives. The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.	Notes: • Unclear which partner will store what records/data

4.3.3.4 Staffing (Marked): 25 Points Available

Response is limited to 30 pages. In Amendment 4 (RFQ Q&A), Offerors were directed to assume a 125,000 Member enrollment in their CCO.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification. The Offeror will describe the following: 1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees. 2. Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees. 3. Describe staff who will be assigned to the quality management program and their qualifications. 4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a Member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers. 5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include whether the entity has successfully received accreditation for other state managed care programs, met required time	Notes: • Offeror includes a good ratio of call center representatives to members (1:4,250) • Offeror lacks clarity regarding who will hold accreditation – TrueCare or Care Source

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
frames to achieve accreditation, and any unsuccessful attempts. 6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications. 7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract. 8. Describe staff who will be responsible for subrogation and Third-Party Liability activities, including staffing levels and qualifications. 9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications. 10. Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared	

Proposer: TrueCare

4.3.3.5 Subcontractors (Marked): 20 Points Available

Response must include a narrative of no more than three (3) pages and applicable form(s) from Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services. For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.	

Proposer: TrueCare

4.3.3.6 Economic Impact (Marked): 20 Points Available

Response must be provided using Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors. Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.	Notes: • Described diverse array of programs for added investment in Mississippi • Offeror described investments within the State that showed an understanding of the needs of Mississippi • Offeror provided good detail for expected investments, including commitments of Capitation payment reinvestments • Starting pay at minimum of $16 hourly rate • Offeror appears to describe impacts beyond what TrueCare is proposing and may be including potential economic impacts that would occur regardless of RFQ outcome

[END OF 4.3.3, ORGANIZATION AND STAFFING]

4.3.4 Management and Control

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

4.3.4.1 Day-to-Day Management (Marked): Pass/Fail

Response is limited to 20 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Program management approach; 2. Program control approach; 3. Manpower and time estimating methods; 4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable). 5. Management of performance standards, milestones, and/or deliverables; 6. Internal quality control monitoring; 7. Program status reporting, including examples of types of reports; and, 8. Approach to the Division's interaction with contract management staff.	

Proposer: TrueCare

4.3.4.2 Problem Management (Marked): Pass/Fail

Response is limited to 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Assessment of program risks and approach to managing them; 2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and 3. Approach to problem identification and resolution.	

Proposer: TrueCare

4.3.4.3 Backup Personnel Plan (Marked): Pass/Fail

Response is limited to 5 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff to allow for effective Division support	

4.3.4.4 Emergency Preparedness (Marked): Pass/Fail

Response is limited to 5 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of public enemy, occur during the life of the Contract.	

[END OF 4.3.4, MANAGEMENT AND CONTROL]

Proposer: TrueCare

Evaluation Team Consensus

Name	Signature	Date
Samantha Atkinson	Samantha Atkinson	7/15/2022 | 2:55:34 PM CDT
Dr. Catherine Brett	Catherine Brett	7/15/2022 | 3:31:18 PM CDT
Jennifer Grant	Jennifer Grant	7/15/2022 | 2:52:54 PM CDT
Keith Heartsill	Keith Heartsill	7/15/2022 | 3:06:24 PM CDT
Sharon Jones	Sharon Jones	7/15/2022 | 2:56:37 PM CDT
Evelyn Sampson	Evelyn Sampson	7/15/2022 | 2:57:33 PM CDT
Jennifer Wentworth	Jennifer Wentworth	7/15/2022 | 2:45:52 PM CDT

Consensus Scoring: UnitedHealthcare of Mississippi, Inc (UHC)

Technical Factors Evaluation
Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991

Offeror B

EVALUATION ROUND 1: TECHNIQAL FACTORS – BLIND SCORING CONSENSUS

Summary of Point Distribution by Section

RFQ Question Set Topic	Related Contract Section(s)	Possible Points	Score
Methodology/Work Statement			
Executive Summary		Pass/Fail	Pass
Member Services and Benefits	Covered Services and Benefits	50	32
Provider Services and Network	Provider Services	50	27
Care Management	Care Management	50	25
Quality Management	Quality Management	50	25
Utilization Management	Quality Management, Throughout the Draft Contract	50	27
Information Technology	Throughout the Draft Contract	20	12
Subcontractual Relationships and Delegation	Subcontractual Relationships and Delegation	20	6
Financial and Data Reporting	Throughout the Draft Contract	15	7
Program Integrity	Fraud, Waste, and Abuse. Throughout the Draft Contract	15	8
Subrogation and Third-Party Liability	Third-Party Liability	10	5
Eligibility, Enrollment, and Disenrollment	Eligibility, Enrollment, and Disenrollment	10	6
		340	**180**
Innovation and Commitment			
Value-Based Purchasing	Quality Management	20	10
Patient-Centered Medical Homes	Provider Services	10	7
Social Determinants of Health	Throughout the Draft Contract	20	12
Value-Adds		10	8
Performance Improvement Projects	Quality Management	10	2
Health Literacy Campaigns	Quality Management	10	4
Telehealth	Covered Services and Benefits	10	6
Use of Technology	Member Services, throughout the Draft Contract	10	7
Potential Partnerships	Throughout the Draft Contract	10	6
		110	62
Total Points		**450**	**242**

Offeror B

Rating Guide

Rating for Applicable Section	50 Possible Points	20 Possible Points	15 Possible Points	10 Possible Points
Excellent Value (100%) Response exceeds expectations for many or all aspects of requirements and at least satisfies all aspects of requirements.	50	20	15	10
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	16	12	8
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	12	9	6
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	8	6	4
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	4	3	2
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0

Technical Factors Evaluation
Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991

Offeror B

Executive Summary (Pass/Fail)
Response is limited to 10 pages

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Did the Executive Summary include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of: • Proposed work plan; • Staff organizational structure; • Key personnel; and, • A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements? 2. Did the Executive Summary demonstrate the Offeror's understanding of the Division's vision for the Contract?	

Offeror B

Methodology Work Questionnaire (MWQ)

Directions from the RFQ:

Please respond to the questions. These statements and questions relate directly to the Major Program Elements described in Section 1.3.7 of this RFQ and related requirements set forth in Appendix A, Draft Contract. Please respond completely but succinctly. When specified, page limits indicate the maximum length of a response. Offerors are encouraged to respond in fewer pages if that is possible. Indicate "not applicable" to any item that is not relevant to the Offeror's qualification. Required documentation for specific answers will not be included as part of page limits and should be included in the body of the response, not as an attachment, unless otherwise indicated.

Unless specified, questions apply to both MississippiCAN and CHIP. If the Offeror's processes and procedures will differ by program for any requested item, make that distinction in the answer.

The Offeror should not construe a Contract section's listing as "related," to denote that the section listed is the only section in which the Question Set Topic is mentioned. The Offeror is responsible to reading and understanding all parts of the Appendix A, Draft Contract, and using that information to be responsive to the Question Sets.

The Offeror is reminded of the prohibition against including identifying information in any of answers. Where model documents are requested, the Offeror must remove all identifying information. Failure to comply with this rule may be basis for disqualification.

Unless specified, questions apply to both MississippiCAN and CHIP. If the processes for both are the same, note that. If the processes are different, make the distinction.

As noted above, the total number of points available for responses to this subsection is 340 points. Points available per element of this subsection are included in the element's title.

Offeror B

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available

Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each.

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Delivery of Covered Services 1. Children a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following: i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach	Notes: • Proposed clinical onsite member screening benefit • Health equity incentive • NET services for CHIP as a value add • Virtual remote monitoring for diabetes • Array of screening tools used for behavioral health services • Including respite program for families of children with SED • Will partner with schools for school-based care and providing iPads • Flex funding to help with non-medical related needs • Behavioral Health was clear and comprehensive. Very actionable. • Interesting approach to group prenatal classes and group doula classes • Enhanced value adds for the foster care population • Providing health care records to MDCPS and foster/adopted parents • Enhanced benefit for NET to perinatal and neonatal visits • Dependence on provider to access portals for care gap closure without any push notification/alert to the provider. • Lack of innovation by only using HEDIS Measures as primary identifier for members in need of care

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, Immunizations, Well-Child visits, and any other services described in the CHIP State Health Plan. Include the following: 1. An overview of related policies, procedures, and processes 2. An overview of how the Offeror will encourage Members to obtain services 3. How the Offeror anticipates the approach will improve health outcomes 4. The Offeror's process for reminders, follow-ups, and outreach to Members 5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance 6. Any innovative methods that Offeror will use to augment its approach b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children? 2. Behavioral Health Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral	• No detail on how the responder plans to collaborate with DOM or use of resources • Lack of detailed response regarding CHIP cost sharing • Response lacks specificity and actionable language

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
health/substance use disorder, including compliance with the SUPPORT Act. c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services? 3. Perinatal and Neonatal a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services. b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services. c. Describe any innovative methods that Offeror will use to augment its approach. d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services? 4. Chronic Conditions a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes. b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally. c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally. d. Describe any innovative methods that Offeror will use to augment its approach.	

Offeror B

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions? 5. Foster Children a. Describe the Offeror's experience and/or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs. b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population. c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in its efforts to accurately identify and subsequently serve the medical needs of foster children and youth. d. Describe any innovative methods that Offeror will use to augment its approach. e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children? 6. Dental Services a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services? 7. Vision Services	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services. b. Describe any innovative methods that Offeror will use to augment its approach. c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding vision services? 8. Additional Items a. State whether the Offeror will required any cost-sharing or copayments from MississippiCAN and/or CHIP Members. i. If yes, please describe what these cost-sharing/copayment requirements will be. b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP). c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section. d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services. **B. Member Services Call Center** 1. Describe the Offeror's Member services call center operations, including: a. Confirming that the location of the proposed operations will be within the State of Mississippi (provide a yes or no answer; do not include address); b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure	

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
standards are met (the Division retains the right to approve all call center standards); c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available; d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled; e. Training program for call center employees including cultural competency and Care Management; f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime; g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week; 2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities. **C. Member Handbook** 1. Describe how the Offeror's Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services. 2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System? **D. Website and Mobile Application** 1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application. 2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any).	

Offeror B

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Member Education and Communication 1. Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use. 2. Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use. 3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including: a. An overview of the program, including accountabilities and proposed activities; b. The Offeror's rationale for selecting areas of focus; c. How the Offeror will ensure that materials are at a third (3rd) grade reading level; d. The language alternatives available to non-English speakers/readers; and, e. How Members who are visually and/or hearing impaired will be accommodated. 4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities. 5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe. 6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract. 7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104.	

Offeror B

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available. 8. Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services. 9. Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division. **F. Member Satisfaction** 1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties. **G. Member Appeals** 1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract; b. Process for expedited review; c. Involvement of Members and their families in the Grievance and Appeal process; d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements;	

Offeror B

MWQ 4.2.2.1: Member Services and Benefits (Unmarked): 50 Points Available	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. How Grievances are addressed prior to the filing of a Member appeal; and f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.	

[END OF SECTION]

Offeror B

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)

Response Limit: 45 pages, plus model provider contracts

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Provider Network 1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include: a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts; b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network; c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities; d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy; e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PMHCs' compliance with availability and scheduling appointment requirements and ensuring Members have	Notes: • Provider services call center has ability to record messages and return the calls the next day • Details provided regarding adaptation to State CVO and credentialing process • An expansive list of provider incentives was included, specifically VBP arrangements with dentists and pharmacists • Will maintain active relationships with telehealth providers across the country and ensure they are enrolled with MS Medicaid. • Innovative approach to partner with EMS to provide Treatment in Place (TIP) for members in need of in-person care, but not emergency care • Robust training for Provider Representatives before they are assigned a territory, including Medicaid policy training. • Response lacks specificity and actionable language • Statistics provided on timeliness of provider grievances and appeals resolutions, but did not reference the percentage of quality or accuracy of decisions and whether overturned • The Medical Group Participation Agreement lists time to file claims as 90 days. This conflicts with the MS managed care contract which lists 180 days. • The Provider Training and Provider Representative training lacks detail regarding claims training

Offeror B

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and, f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network. g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy. 2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities. 3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. 4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete. 5. Submit templates of the Offeror's standard Provider contracts. 6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including: a. System used to identify and notify Members affected by Provider loss;	

Offeror B

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
b. Automated systems and membership supports used to assist affected Members with Provider transitions; c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition; and, d. Approach to cover membership needs with existing network resources following terminations. 7. Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care. 8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to: a. Issue IRS 1099 forms, b. Meet all federal and Division reporting requirements, and c. Cross-reference to state and federal identification numbers to identify and report excluded Providers. **B. Provider Services Call Center** 1. Describe the Offeror's Provider services call center operations including: a. Hours of operation; b. Describe how the Offeror will ensure call center employees will have cultural competency; c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards);	

Offeror B

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
d. Training program for call center employees including local and statewide cultural competency; and, e. A description of any plans to use electronic communication to respond to Provider inquiries. 2. Describe how the Offeror will assess the quality and efficiency of the Call Center. **C. Provider Education and Communication** 1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system. 2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a Member for behavioral health/substance use disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems. 3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections. 4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics. 5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.	

Offeror B

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties. 7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services. 8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances: a. Perinatal; b. Behavioral Health; c. Substance Use Disorder; d. Chronic Conditions; and e. Foster Children. **D. Collaboration with Providers** 1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity. 2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care. 3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members.	

Offeror B

MWQ 4.2.2.2: Provider Network and Services (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Provider Payment 1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis. 2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Offeror's claims processing system. 3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s). **F. Provider Grievances and Appeals** 1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing: a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract; b. Process for elevating Provider Grievances; and, c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.	

[END OF SECTION]

Offeror B

MWQ 4.2.2.3: Care Management (50 Total Possible Points)

Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages.

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Care Management Proposal 1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response: a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach; b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities; c. How the Offeror will ensure that Care Management is a tool to address health equity concerns; d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and, e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high). **B. Stratification and Assignment** 1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking	Notes: • Automated care manager reminders within 7 days of referral • Outreach plan detailed on notifying providers of members who declined care management • Details a unique care management and partnership referral report • Lack of comprehensive, statewide programs • Lacks overall detail and actionable steps • Inadequate management of low-risk populations with limited resources provided and extended re-evaluation timelines • Lack of sufficient details on evaluation of health equity o no inclusion of timeline for population health director and health equity director to review or enact improvements to interventions based on analysis of outcome measure • No mention of coordination with statewide HIEs • Insufficient details of an overall communication strategy to DOM

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
answers, and how answers will be used for stratification of Members based on acuity levels and Care Management. 2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management. 3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment with the Offeror in order to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment. 4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools. 5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA. **C. Care Management Services** 1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
notify Members and/or Providers when follow-up is due. Address the following issues in the response: a. Facilitation and monitoring of Member compliance with treatment plans; b. Partnerships of community-based partnerships and other state agencies; and c. Coordination with other Providers. 2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in identifying and gaining access to community resources that may provide services not covered. 3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response: a. The Offeror's role and the PCP's/PCMH's role in this process; b. Examples of information that the Offeror will provide to Providers; c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and, d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation. e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties. **D. Transition of Care** 1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process. 2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including: a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services; b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff; c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and, d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and network pharmacist to assure continuation of needed therapy. 3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation.	

Offeror B

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
E. Staff 1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following: a. Education and training required for Care Managers; b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers; c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases; d. And overview of the Offeror's continuing education and training plan for its Care Managers; and e. Expected wages to be paid to Care Managers (hourly/salary and what amounts). **F. Hypotheticals** 1. Describe the Offeror's approach to providing Care Management in the following scenarios: a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months; b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable; c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health	

MWQ 4.2.2.3: Care Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
needs was admitted last night to a local inpatient facility after presenting with an asthma attack; d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week; and, e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a Member.	

[END OF SECTION]

Offeror B

MWQ 4.2.2.4: Quality Management (50 Total Possible Points)

Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to 10 pages.

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Quality Management Program 1. Describe the Offeror's proposed quality management program, including: a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable; b. The program's lines of accountability; c. Process for selecting areas of focus; d. Process for using evidence-based practices; e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy; f. Use of data to design, implement and evaluate the effectiveness of the program; g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and h. How the Offeror will address health access and equity in its quality management program 2. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages). **B. Clinical Guidelines and Compliance** 1. Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines.	Notes: • Proposes partnership with other CCOs to lead the standardization of clinical practice guidelines • Lacks overall actionable steps to drive quality outcomes • Lacks specificity on how they would use advanced data & analytics • Lack of substance on how to address SDOH strategies • No assigned contact for quality tracking • Inadequate frequency of Committee/sub-committee meeting timelines • Insufficient details of an overall communication strategy to DOM

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 3. Describe the Offeror's proposed process for compliance with the SUPPORT Act. 4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines. 5. Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered. 6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers. 7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for precluding payment to Providers and reporting to the Division via encounter data in accordance with 42 C.F.R. § 438.3. 8. Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions. **C. Quality Measurement** 1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract. a. Describe the type of build necessary to create these types of reports.	

Offeror B

MWQ 4.2.2.3: Quality Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidences efficacy of programs.	

[END OF SECTION]

Offeror B

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)

Response Limit: 30 pages

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to utilization management, including: a. A description of the utilization management program; b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures; 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 used to develop utilization review criteria; e. Expected Prior Authorization clinical criteria by program area; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates; g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization; h. The Offeror's approach to reducing the number of Prior Authorizations required; i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and	Notes: • Innovative strategy to treat in place (TIP) by EMS to avoid potential ER visit • Has experience in another state with a single PBA • Strong prior authorization process • Provides a method for Members to see gaps in their own care via mobile app • Lacks detail on how the Offeror will cooperate with provider on Potentially Preventable Hospital Returns (PPHR) • Restates RFQ section requirements without providing adequate details to support an understanding of the requirements

Offeror B

MQW 4.2.2.5: Utilization Management (50 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
j. Processes to ensure consistent application of criteria by individual clinical reviewers. **B. Methods** 1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy. 2. Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program. 3. Describe how the Offeror will identify and address trends in over- and under-utilization. 4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members. 5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.	

[END OF SECTION]

Offeror B

MQW 4.2.2.6: Information Technology (20 Total Possible Points)

Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages.

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Claims Processing 1. Describe the Offeror's claims processing system including: a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program. 2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion. 3. Describe the Offeror's claims processing operations including: a. The claims processing systems that will support this program; b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program; c. The Offeror's process for dealing with discovered compliance issues through an expedited process; d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an	Notes: • Planned system upgrade scheduled • Extensive data sharing processes with contractors across systems and subsystems, and flow to the subcontractors, i.e., eligibility, utilization management, quality improvement, and care management • Dedicated team for claims monitoring and quality assurance • Invests $3.5B annually in technology and innovation across IT portfolio • Valuable member touch-point tracking tool used in quality management • Effective use of technology to provide utilization data to acute care managers • The timeline for any payment or recoupment related to system corrections was missing • Use of the offeror's vendor's single national repository of provider information as the source of truth may conflict with DOM provider information

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
example of how the Offeror has addressed these deficiencies or variances. **B. Technological Systems** 1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System. 2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies. 3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate. 4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies. **C. Innovation** 1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members. 2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network. 3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division. **D. Continuity of Operations** 1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including a. Employee training; b. Essential business functions and responsible key employees;	

Offeror B

MQW 4.2.2.6: Information Technology (20 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; d. Communication with staff and suppliers when normal systems are unavailable; e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components; f. Security and privacy requirements; and g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.	

[END OF SECTION]

Offeror B

MQW 4.2.2.7: Subcontractual Relationships and Delegation (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Services to be Subcontracted 1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor. 2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor. **B. Subcontractor Oversight** 1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will: a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor; b. Ensure receipt and reconciliation of all required data including encounter data; c. Ensure appropriate utilization of health care services; d. Ensure delivery of administrative and health care services meets all standards required by this RFQ; e. Ensure adherence to required Grievance policies and procedures; and, f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how	Notes: • Failed to completely respond to A.2. describing the offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. • Does not allow sufficient time for DOM to review material alterations to subcontracts and not in line with the draft contract requirements • Restates RFQ section requirements without providing adequate details to support an understanding of the requirements

Offeror B

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
the Offeror has addressed a deficiency or contractual variance with a Subcontractor. g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division. h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.	

[END OF SECTION]

Offeror B

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)
Response Limit: 20 pages

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Financial Reporting 1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c). 2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized. **B. Data Reporting** 1. Encounter Data a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan. 2. Health Information System Data a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes,	Notes: • Offeror will use financial data across a wide variety of applications • Variance between the vendor proposal and contract regarding timeframes for document retention • Variance between required basis of audited financial statement preparation

Offeror B

MQW 4.2.2.8: Financial Data and Reporting (15 total possible points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
integrates, validates, and reports data including but not limited to the following areas: i. Utilization, ii. Claims, Grievances and Appeals, iii. Disenrollment (for other than loss of Medicaid eligibility), iv. Member Characteristics, v. Provider Characteristics, vi. Care Management Utilization, vii. Clinical Data, and viii. Population Health.	

[END OF SECTION]

Offeror B

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)

Response Limit: 20 Pages

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Fraud, Waste, and Abuse 1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including: a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable; b. Process for acting upon suspected cases of fraud, waste and abuse; c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers; d. Process for interacting with the Division, including the Office of Program Integrity; and, e. Other components of the Offeror's fraud, waste, and abuse program. **B. Claim Denials** 1. Describe the Offeror's proposed Denials Review and Reporting program, including: a. A description of the Offeror's Denials Management program; b. A summary/listing of the Offeror's denials criteria/protocol; c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria; d. The Offeror's reconsideration process as it relates to claims denials; and	Notes: • Significant details provided about process for how they will conduct program integrity • Prepayment reviews are completed in twelve months, which DOM considers an excessively long period of time. • Proposal did not show a commitment to providing DOM information/data for program Integrity uses.

Offeror B

MQW 4.2.2.9 Program Integrity (15 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
e. The Offeror's process for notifying and educating providers of claims denials. **C. National Correct Coding Initiative (MississippiCAN)** 1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.	

[END OF SECTION]

Offeror B

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)
Response Limit: 10 pages

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. Approach 1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including: a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division; b. Process for retrospective post payment recoveries of health-related insurance; c. Process for adjudicating claims involving third party coverage; d. Process for identifying, recouping, and releasing claims; e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP; f. Data analytics and informatics used to support the process; and, g. Process for providing supplemental third-party data and files to the Division. h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes. 2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best practices" to ensure that they are optimizing the TPL recoveries on behalf of the Division? a. If yes, describe the Offeror's process.	Notes: • Proposal stated that the responder is willing and able to share additional TPL data with DOM, which will provide more comprehensive TPL information for DOM and providers • Not enough statistical information • Lack of data to support the RFQ response

Offeror B

MQW 4.2.2.10: Subrogation and Third-Party Liability (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
B. Effectiveness 1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective. 2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.	

[END OF SECTION]

Offeror B

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)

Response Limit: 15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C(1)(e) (optional). Each appendix is limited to five (5) pages each.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A. File Management 1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses. 2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including: a. Process for outreach and engagement of Members; b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program; and c. The Offeror's draft disenrollment survey. **B. Assignment of Members to a Primary Care Physician** 1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to: a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection; b. Track data to confirm that every Member is assigned; c. Inform PCPs/PCMHs of new Members within the required time frames; and d. Confirm that PCPs/PCMHs received the list of assigned Members.	Notes: • Automated 834 enrollment file updates will be completed on the same day the state file is received, and any needed Manual reconciliation will be completed by the next business day • Proposal states that Primary Care Physician roster contains clinical data to support whole person care – HEDIS, GAPS, IH Admits, ER Discharge. Provider may run roster reports on-demand. • Offeror did not provide subcontractor details regarding timely processing of the member eligibility file, as subcontractors are required to meet the same requirements as the CCO. • Automated calls instead of person-to-person calls to members about their PCP or PCMH are not of most benefit to DOM Members.

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members. 3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment. 4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs. 5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments. 6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments. **C. Member Information** 1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following: a. Language alternatives that will be available; b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract;	

Offeror B

MQW 4.2.2.11: Eligibility, Enrollment, and Disenrollment (10 Total Possible Points)	
REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses; and d. Process for following up with Members whose information packets or identification cards are returned. e. Offeror may choose to include sample member materials in excess of the page limit.	

[END OF SECTION]

[END OF METHODOLOGY WORK QUESTIONNAIRE]

Offeror B

Innovation and Commitment (I&C)

From the RFQ:

Central to the Division's strategy for the next contract cycle are a number of new and/or improved initiatives it plans to implement. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans). The Offeror should also be attentive to standards and expectations described in Appendix A, Draft Contract, in designing its proposals.

After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.

As noted above, the total number of points available for responses to this subsection is 110 points. Points available per element of this subsection are included in the element's title.

Offeror B

I&C 4.2.3.1: Value-Based Purchasing (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a strategy to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. The program must describe how the CCOs will work collaboratively with the Division's subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. The Offeror must produce a Value-Based Purchasing proposal for the Division, considering the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • Includes additional provider types with the incentives and provides details regarding the Alternative Payment Models • Limited details regarding communication strategy with DOM

[END OF SECTION]

Offeror B

I&C 4.2.3.2: Patient-Centered Medical Home (PCMH) (10 Total Possible Points)
Response Limited: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle. PCMHs should be made available to all medium- and high-risk Members. The system is discussed more in Section 6.2.5, Patient-Centered Medical Homes, of Appendix A, Draft Contract. The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through with PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.	Notes: • For NCQA recognized PCMHs, Offeror will pay them twice as much per gap closure than non-PCMHs in the Quality Gap Closure programs. • Clinical transformation model: Nurse consultants work with providers to develop a Clinical Action Plan to evaluate performance across the six pillars as displayed in Figure 3, combining quality and clinical components, as well as value-based care, population health, and data exchange and advanced analytics. • Proposal states that foundational to the Offeror's PCMH proposal is developing true partnerships with providers and PCMHs to continually improve capacity for advanced team-based care and care management. • Lacks information for PCMH recruitment or development

[END OF SECTION]

Offeror B

I&C 4.2.3.3: Social Determinants of Health (20 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions: 1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data. 2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations? 3. What approaches will the Offeror take to address these challenges? 4. How will the Offeror address Health Equity through its SDOH programs? 5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)? Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches. **The Social Determinants of Health: Staffing table does not count against the Offeror's response limit to this question.**	Notes: • Use of GIS • Unique details in Member Supports and Programs • Unique housing supports • Details well-structured and diversified approach to SDOH (ex. targeted interventions) • Offers to both CAN and CHIP members GED education • Restates verbiage of RFQ without actionable steps of the SDOH strategy

[END OF SECTION]

Offeror B

I&C 4.2.3.4: Value Added Benefits (10 Total Possible Points) (No page limit)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of Division-curated Value-Adds are included in Appendix E. The Offeror may choose from the Division's list of value-adds, describe some of their own, both, or elect not to include value-adds in its proposal. If no Value-Adds are included, the Offeror will receive a score of zero for this section. If offering any Value-Add in its response, the Offeror should make summary proposals of any and all Value- utilizing the following charts provided in Appendix E: • Value-Added Benefit: Summary Chart • Value-Added Benefit: Staffing (if applicable) If the Offeror is not including Value-Adds with its proposal, the Offeror should use the form provided in Appendix E as its answer to this request.	Notes: • Will offer enhanced dental and vision benefits, pest control, independent living support, NET services for CHIP, NET services for Pregnant Women, etc. • Provides an opportunity for members to obtain Career Coaching • Contains a broad variety of Value-Added Benefits • Includes Value-Added Benefits that are relevant to the population served • Does not provide specific parameters to eligible population on proposed value-added benefits

[END OF SECTION]

Offeror B

I&C 4.2.3.5: Performance Improvement Projects (10 Total Possible Points)

Response Limit: 4 PIP Proposals pages: 2 for CHIP and 2 for MSCAN + staffing pages (if applicable)

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, both for the purposes of scalability and measurement. This is discussed more in Section 8, Quality Management, of Appendix A, Draft Contract. After selection, Contractors will submit their PIPs to the Division for standardization, and Contractors will be required to cross-collaborate on at least one PIP. The Offeror should include with its proposal summaries of its first year of proposed Performance Improvement Projects for MississippiCAN and CHIP. To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs utilizing the following charts provided in Appendix E: • Performance Improvement Project: Summary Chart • Performance Improvement Project: Staffing (if applicable)	Notes: • Use of SMART Goals for majority of PIPs proposed • Clear understanding of problem for proposed Sickle Cell PIP; clear end points and clear evaluation tools used • Response fails to address requirements of a collaborative PIP • Overall, proposed PIPs are too broad, with too many interventions/activities, and too many measures to accurately track a successful PIP. • Obesity PIP did not meet expectations for a PIP, no clear objective, insufficient detail, and no clear end points/evaluations. Therefore, did not meet requirement for RFQ. • Insufficient details of an overall communication strategy to DOM

[END OF SECTION]

Offeror B

I&C 4.2.3.6: Health Literacy Campaigns (10 Total Possible Points)
Response is limited to 4 campaigns + staffing pages if applicable

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The Division plans to coordinate a common strategy among Contractors in order to best amplify important health education to Members. More details can be found in Section 8.10.8, Health Literacy Campaigns, of Appendix A, Draft Contract. To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns utilizing the following charts provided in Appendix E: • Health Literacy Campaign: Summary Chart • Health Literacy Campaign: Staffing (if applicable)	Notes: • Health Literacy Topics do not appear to be innovative

[END OF SECTION]

Offeror B

I&C 4.2.3.1: Telehealth (10 Total Possible Points)
Response Limit: 8 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals form Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.	Notes: • Will ensure all telehealth providers are MS Medicaid providers • Plans to allow teledentistry for oral health emergencies • Offers a mobile phone/tablet program that is thorough, and the hot spot is an extra benefit • Use of exclusionary language limits what would otherwise be a true and invaluable broadband benefit

[END OF SECTION]

Offeror B

I&C 4.2.3.8: Use of Technology (10 Total Possible Points)
Response Limit: 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs: 1. Data gathering and analysis 2. Efficacy of initiatives and programs 3. Transparency	Notes: • Innovative use of technology described within the response (e.g., GIS, Claims Pattern Identifier) • Offeror states that DOM will have access to the Offeror's portal and system • Highly detailed; committed to transparency by providing access to the systems and data when appropriate • Real-time access to patient data accomplished through the HIE with connections to the hospitals' EHRs

[END OF SECTION]

I&C 4.2.3.9: Potential Partnerships (10 Total Possible Points)

Response Limit: 8 partnerships total: 4 Potential Partnerships, 4 Potential Care Management Partnerships

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. This requirement is discussed through Appendix A, Draft Contract. The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners. The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs. This requirement is discussed in detail in Section 7, Care Management, of Appendix E. The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners. The Offeror may not duplicate potential partners in answering either part of this request. The Offeror should not include in its answer any information regarding any current or prior relationship with a proposed partner. The Offeror's explanation for choosing the Offeror should describe how work with the proposed partner directly connects to requirements of Appendix A, Draft Contract, and this RFQ, with no reference to any other contract or lines of business of the Offeror.	Notes: • Selected charities align with Medicaid goals • Financial commitments are noted as per year for some partnerships • Partnerships are statewide • Missed opportunity by not including the MS Dept of Education due to a large EPSDT population • Stated financial commitment seems to be incongruent with what would be needed to support these partnerships because they are statewide

[END OF SECTION]

[END OF INNOVATION & COMMITMENT]

Offeror B

Evaluation Team Consensus

Name	Signature and Date
Samantha Atkinson	Samantha Atkinson 5/23/2022 | 11:51:12 AM CDT
Dr. Catherine Brett	Catherine Brett 5/26/2022 | 2:21:02 PM CDT
Jennifer Grant	Jennifer Grant 5/20/2022 | 4:09:43 PM CDT
Keith Heartsill	Keith Heartsill 5/23/2022 | 9:58:55 AM CDT
Sharon Jones	Sharon Jones 5/19/2022 | 7:43:29 PM CDT
Evelyn Sampson	Evelyn Sampson 5/20/2022 | 2:17:11 PM CDT
Jennifer Wentworth	Jennifer Wentworth 5/20/2022 | 8:57:10 AM CDT

Management Factors Evaluation
Division of Medicaid Coordinated Care Organization RFQ
RFQ # 20211210
RFx # 3150003991

Proposer: United HealthCare of Mississippi, Inc.

EVALUATION ROUND 2: MANAGEMENT FACTORS – MARKED/INFORMED CONSENSUS SCORE

Summary of Point Distribution by Section

RFQ Question Set Topic	Points Available	Score
Corporate Background and Experience		
Corporate Background: Biographical Information	20	12
Corporate Background: Corporate Resources	50	32
Corporate Experience	30	20
	100	**64**
Ownership and Financial Disclosure Information		
Information to be Disclosed	Pass/Fail	Pass
When and to Whom Information Will Be Disclosed	Pass/Fail	Pass
Information Related to Business Transactions	Pass/Fail	Pass
Change of Ownership	Pass/Fail	Pass
Disclosure of Identity of Any Person Convicted of a Criminal Offense	Pass/Fail	Pass
Audited Financial Statements	Pass/Fail	Pass
Organization and Staffing		
Organization	10	5
Job Descriptions and Responsibilities	20	13
Administrative Requirements	5	5
Staffing	25	14
Subcontractors	20	12
Economic Impact	20	10
	100	**59**
Management and Control		
Day-to-Day Management	Pass/Fail	Pass
Problem Management	Pass/Fail	Pass
Backup Personnel Plan	Pass/Fail	Pass
Emergency Preparedness Plan	Pass/Fail	Pass
Total Points	**200**	**123**

Proposer: United HealthCare of Mississippi, Inc.

Rating Guide

Rating for Applicable Section	50 Points	30 Points	25 Points	20 Points	10 Points	5 Points
Excellent Value (100%) Response exceeds expectations on all aspects of requirements and at least satisfies all aspects of requirements.	50	30	25	20	10	5
Very Good Value (80%) Response satisfies all requirements and has some benefits above requirements. Response exceeds specified performance requirements or capability in a beneficial way.	40	24	20	16	8	4
Good Value (60%) Response clearly satisfies requirements without need for correction. Any proposal inadequacies or weaknesses are minor or readily correctable.	30	18	15	12	6	3
Fair Value (40%) Response satisfies some requirements but not all requirements. Has some weaknesses that may be correctable.	20	12	10	8	4	2
Poor Value (20%) Response fails to meet all or most of the requirements. Has serious weaknesses that may not be correctable.	10	6	5	4	2	1
Non-Responsive (0%) Response fails to address requirements or merely mentions requirements without being responsive to the elements of the requirement. Response is completely unacceptable or missing.	0	0	0	0	0	0

4.3.1 Corporate Background and Experience (100 points available)

From the RFQ:

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, and details of corporate experience relevant to the proposed Contract including all current or recent MississippiCAN, CHIP, or related projects.

4.3.1.1 Corporate Background

This section has two subparts:

- 4.3.1.1.1 Biographical Information
- 4.3.1.1.2 Corporate Resources

4.3.1.1.1: Corporate Background: Biographical Information (Marked): 20 Points Available

Response must be provided using the form included in Appendix F of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
See Appendix F, form entitled "Biographical Information"	Notes: • Holds NCQA Multicultural Distinction • Lacking details of innovation for the market

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4.3.1.1.2: Corporate Background: Corporate Resources (Marked): 50 Points Available

Response is limited to 40 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror may answer the following questions using narratives, charts, and lists as appropriate. • Describe the Offeror's Computer and Technological Resources • Describe the Offeror's Current Products and Services • Describe the Offeror's Intangible Assets • Describe any unique and/or innovative resources in which the Offeror specializes • Describe additional resources of the Offeror	Notes: • Offeror provides a good description of intangible assets • Offeror demonstrates multicultural healthcare distinction • Offeror includes a good array of alternatives to assist providers with beneficiary care • Offeror demonstrates a strong investment in technology resources • Offeror will provide additional services to members • Offeror demonstrates too much reliance on national programs • Offeror lacks details regarding innovation outside of RFQ/Contract requirements

4.3.1.2: Corporate Experience (Marked): 30 Points Available

Response must be provided using the form included in Appendix F of the RFQ (form entitled "Corporate Experience: Current and/or Recent Client.")
If the Offeror does not have the requested experience, then they must provide a narrative explanation not to exceed three (3) pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000. [Clarification about 400,000: The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.] If the information requested above is not available, the Offeror must provide a narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.	Notes: • Offeror showed diversity in population served and density of populations • Offeror terminated contracts due to failed rate negotiations

[END OF 4.3.1 CORPORATE BACKGROUND AND EXPERIENCE]

4.3.2 Ownership and Financial Disclosure Information

From the RFQ:

For many of the requirements of this section, the Offeror should utilize forms provided in Appendix G: Ownership and Financial Disclosure Information. If a form has been provided in this RFQ to respond to a requirement, no other response will be accepted.

4.3.2.1: Information to Be Disclosed (Marked): Pass/Fail

Response must be provided using the forms included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(b), the Offeror shall make certain disclosures. The Offeror must use the forms provided in Appendix G to provide this information. Titles of Forms that should be used: • Section 1: Ownership Interest and/or Managing Control Identification Information – subsections of that form: • Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification • Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control • Section 1(c): Familial Relationships • Section 2: Disclosure of Subcontractor Information • Section 3: Other Disclosing Entities	

4.3.2.2: When and to Whom Information Will be Disclosed (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times: 1. Upon the Contractor submitting a qualification in accordance with the State's procurement process; 2. Annually, including upon the execution, renewal, and extension of the contract with the State; and, 3. Within thirty-five (35) days after any change in ownership of the Contractor. In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency. The Offeror must use the appropriate form in Appendix G as its response to this section.	

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4.3.2.3: Information Related to Business Transactions (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must use the appropriate form in Appendix G to provide this information. In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about: 1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and, 2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request. If the Offeror does not have information responsive to this request, then they should sign the attestation provided in Appendix G. If the Offeror does have information responsive to this request, they it should provide that information with the form(s) entitled Business Transactions with Subcontractors and Significant Business Transactions in Appendix G, as applicable.	

4.3.2.4: Change of Ownership (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
A change of ownership of the Offeror includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Offeror. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. The Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of the Contractor. Should the Contractor undergo a change of direct ownership, the Contractor must notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract. If the Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to the Division in writing within sixty (60) calendar days of the end of each quarter. If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract. **If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the appropriate attestation included in Appendix G as its response to this section. [emphasis added for Evaluator's convenience.]**	

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4.3.2.5: Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked): Pass/Fail

Response must be provided using the form included in Appendix G of the RFQ.

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
In accordance with 42 C.F.R. § 106 (a), the Contractor shall disclose to the Division the identity of any person who: 1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and, 2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. If the Offeror does have a disclosure to make that is responsive to this section, the Offeror must use the appropriate form in Appendix G to make that disclosure and respond to this section. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the attestation included in Appendix G as its response to this section.	

4.3.2.6: Audited/Financial Statements and Pro Forma Financial Template (Marked): Pass/Fail

Response must include information as described below. The Pro Forma Financial Template (referenced as "Three (3) year financial pro forma") was linked in Appendix G of the RFQ. ***NOTE: For the Evaluator's convenience, due to the voluminous nature of these documents, they are in a separate PDF document for each proposal.***

REVIEW *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
Audited financial statements for the contracting entity shall be provided for each of the last three (3) years, including, at a minimum: 1. Statement of income; 2. Balance sheet; 3. Statement of changes in financial position during the last three (3) years; 4. Statement of cash flow; 5. Auditors' reports; 6. Notes to financial statements; and 7. Summary of significant accounting policies. If the information requested above is not available, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support the explanation. Acceptance of the explanation provided is at the discretion of the Division. The Offeror must also submit the following: 1. Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the qualification; and, 2. Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror. The Division reserves the right to request any additional information to assure itself of an Offeror's financial status.	

[END OF 4.3.2, OWNERSHIP AND FINANCIAL INFORMATION]

4.3.3 Organization and Staffing

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state.

The Offeror is not allowed to list the name of staff in its response.

4.3.3.1 Organization (Marked): 10 Points Available

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The organization charts shall show: • Organization and staffing during each phase as described in the RFQ; • Full-time, part-time, and temporary status of all employees; and • Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared. For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."	Notes: • Offeror presented organizational chart with similar staff grouped together, including reporting and data analytics team included in Operations • Offeror included an organizational chart legend that was confusing

4.3.3.2 Job Description and Responsibilities of Key Positions (Marked): 20 Points Available

Response should use form in Appendix H for all positions listed below. The Offeror may not submit resumes or other information identifying current or prospective employees who are expected to fill the subject positions if the Offeror wins the contract.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
RFQ Instructions: The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract. The Offeror must use the appropriate form provided in Appendix H to respond to this request. **Positions required by Draft Contract Section 1.13 Administration Management, Facilities, and Resources provided for Evaluator's convenience.** **Draft Contract Section 1.13.1.1 Executive Positions** (refer to Draft Contract for full position description): 1. Chief Executive Officer 2. Chief Operating Officer 3. Chief Financial Officer 4. Medical Director 5. Perinatal Health Director 6. Behavioral Health Director 7. Chief Information Officer 8. Compliance Officer 9. Project Manager **Draft Contract Section 1.13.1.2 Administrative** Positions (refer to Draft Contract for full position description): 1. Provider Services Manager 2. Network/Contracting Manager 3. Member Services Manager	Notes: • Clear, concise detail describing minimum job requirements

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
4. Quality Management Director 5. Care Management Director 6. Population Health Director 7. Utilization Management Coordinator 8. Grievance and Appeals Coordinator 9. Claims Administrator 10. Data and Analytics Manager 11. Clinical Pharmacist **1.13.2 Additional Staff Requirements** The Contractor shall also have the following staff located in Mississippi by the beginning of the term of the Contract: 1. A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division; 2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-Network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations; 3. Designated staff to be responsible for Marketing, Member communications, and/or public relations; 4. Sufficient support staff to conduct daily business in an orderly manner (to respond to this question, the Division expects the Offeror to make its own determination regarding what sufficient support staff would be needed for daily business based on its knowledge of its own needs for operation); 5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times; 6. All Care Managers; and 7. A designee or designees who can respond to issues involving systems and	

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract	

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4.3.3.3 Administrative Requirements (Marked): 5 Points Available

Response must be provided using the form included in Appendix H of the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror will verify and answer the following: 1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201- 1399, as required by the RFQ. 2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives. The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.	Notes: • Storage of administrative data • Good descriptions regarding how data will be maintained, location, and security • Offeror has clearly-defined educational requirements, continuing education, and certifications for CIO • Primary copy of data was stored locally and secondary was another location. Specific location of secondary location was not listed

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4.3.3.4 Staffing (Marked): 25 Points Available

Response is limited to 30 pages. In Amendment 4 (RFQ Q&A), Offerors were directed to assume a 125,000 Member enrollment in their CCO.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification. The Offeror will describe the following: 1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees. 2. Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees. 3. Describe staff who will be assigned to the quality management program and their qualifications. 4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a Member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers. 5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include whether the entity has successfully received accreditation for other state managed care programs, met required time	Notes: • Offeror provides generous tuition reimbursement for staff • Offeror provides additional staff opportunities that include a cohort-based healthcare MBA program and a RN-MSN for the nursing staff • Offeror includes a good description of the national support for fraud, waste, and abuse, that includes mandatory training for FWA staff • Offeror fails to specify the number of staff for each category and only lists the ratios. • Offeror lacks clarity between the state entity and the corporate entity when referencing staffing numbers

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
frames to achieve accreditation, and any unsuccessful attempts. 6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications. 7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract. 8. Describe staff who will be responsible for subrogation and Third-Party Liability activities, including staffing levels and qualifications. 9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications. 10. Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared	

4.3.3.5 Subcontractors (Marked): 20 Points Available

Response must include a narrative of no more than three (3) pages and applicable form(s) from Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services. For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.	

4.3.3.6 Economic Impact (Marked): 20 Points Available

Response must be provided using Appendix H from the RFQ.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors. Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.	Notes: • Described substantial investment contributions through diverse programs as future planned investments • Starting pay at minimum of $16 hourly rate • Lack of detailed information in the narrative

[END OF 4.3.3, ORGANIZATION AND STAFFING]

4.3.4 Management and Control

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

4.3.4.1 Day-to-Day Management (Marked): Pass/Fail

Response is limited to 20 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Program management approach; 2. Program control approach; 3. Manpower and time estimating methods; 4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable). 5. Management of performance standards, milestones, and/or deliverables; 6. Internal quality control monitoring; 7. Program status reporting, including examples of types of reports; and, 8. Approach to the Division's interaction with contract management staff.	

Proposer: United HealthCare of Mississippi, Inc.

4.3.4.2 Problem Management (Marked): Pass/Fail

Response is limited to 10 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
1. Assessment of program risks and approach to managing them; 2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and 3. Approach to problem identification and resolution.	

Proposer: United HealthCare of Mississippi, Inc.

4.3.4.3 Backup Personnel Plan (Marked): Pass/Fail

Response is limited to 5 pages

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff to allow for effective Division support	

4.3.4.4 Emergency Preparedness (Marked): Pass/Fail

Response is limited to 5 pages.

REVIEW QUESTIONS *The following are guiding requirements/questions to consider when reviewing. Evaluators are not required to respond to all items in developing comments.*	**REVIEW NOTES** *Strengths/Weaknesses/Questions/Interesting*
The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of public enemy, occur during the life of the Contract.	

[END OF 4.3.4, MANAGEMENT AND CONTROL]

Proposer: United HealthCare of Mississippi, Inc.

Evaluation Team Consensus

Name	Signature	Date
Samantha Atkinson	Samantha Atkinson	7/15/2022 | 2:56:47 PM CDT
Dr. Catherine Brett	Catherine Brett	7/15/2022 | 3:25:45 PM CDT
Jennifer Grant	Jennifer Grant	7/15/2022 | 2:52:09 PM CDT
Keith Heartsill	Keith Heartsill	7/15/2022 | 3:08:13 PM CDT
Sharon Jones	Sharon Jones	7/15/2022 | 2:57:33 PM CDT
Evelyn Sampson	Evelyn Sampson	7/15/2022 | 2:56:53 PM CDT
Jennifer Wentworth	Jennifer Wentworth	7/15/2022 | 2:57:48 PM CDT

Appendix C: Resumes of Contractor Committee Members

Catherine Brett, MD, MPH

Quality Director, UM/QIO

550 High Street, Suite 1000, Jackson MS 39201

[redacted] [redacted]

https://www.doximity.com/pub/catherine-brett-md

Employment

Alliant Health Solutions

- Quality Director, Mississippi UM/QIO
- July 2019 to present

Delta Health Center, Inc.

- Obstetrician & Gynecologist
- October 2015 to May 2017

Wayne General Hospital

- Obstetrician & Gynecologist- August 2010 to September 2015

William Carey University College of Osteopathic Medicine

- Adjunct Clinical Faculty-
- July 2011 to June 2017
    - Preceptor for Years 3 and 4 Medical Students

Education

University of Missouri- Kansas City School of Medicine- Doctor of Medicine

- August 2000 to May 2006
    - Six-year combined program- Bachelor of Arts and Doctor of Medicine degrees
    - Dean's Scholar- September 2000 to July 2004

Arnold School of Public Health - Masters of Public Health

- August 2017 to May 2019
    - With Distinction

Training

Prisma Health/ University of South Carolina – Preventive Medicine Residency

- July 2017 to June 2019
    - Academic Chief Resident 2018 to 2019

Georgetown University Hospital - Obstetrics and Gynecology Residency

- July 2006 to June 2010
    - Academic Chief Resident 2009 to 2010
    - MedStar Award for Outstanding Patient Care 2009

Catherine Brett, MD, MPH

Quality Director, UM/QIO

550 High Street, Suite 1000, Jackson MS 39201

[redacted] [redacted]

https://www.doximity.com/pub/catherine-brett-md

Certification and Licensure

American Board of Preventive Medicine

- Board Certified to December 2030

Lean Six Sigma Certification

- Yellow Belt certification October 2018

Mississippi Medical License

- Active state license to June 2023

South Carolina Medical License

- Active state license to June 2023

Leadership

American College of Preventive Medicine

- National CME/MOC Committee
  - July 2018 to present
  - Prevention 2019 Improvement and Innovation Track Liaison for CME/MOC committee
- National Advocacy Committee
  - July 2020 to present
- Young Physician Section representative for residency

Prisma Health

- Prisma Health Midlands Pharmacy and Therapeutics Committee Representative
  - July 2017 to June 2019
- Preventive Medicine Resident Advisory Committee (RAC) Representative
  - August 2017 to June 2019
- Prisma Health Resident Council Meeting Representative
  - August 2017 to July 2018

University of South Carolina Medical School

- Introduction to Clinical Medicine Course, Spring 2018
  - Facilitator for ICM weekly small group session of 1st Year Medical Students
- Interprofessional Education Course, Spring 2018
  - Facilitator for Root Cause Analysis Case Scenarios

Wayne General Hospital

- Pharmacy & Therapeutics Committee

Catherine Brett, MD, MPH

Quality Director, UM/QIO

550 High Street, Suite 1000, Jackson MS 39201

[redacted] [redacted]

https://www.doximity.com/pub/catherine-brett-md

- January 2011 to September 2015

Georgetown University Hospital

- Quality and Safety Executive Council
  - July 2008 to June 2010

Quality Improvement Activities

Dorn VA Medical Center-

- Process Improvement Committees
  - Women Veteran's Wait Times Process Improvement Committee
    - March 2018 to July 2018
  - Home Telehealth Process Improvement Committee
    - July 2018 to September 2018

American College of Preventive Medicine

- ACPM DesignHack
  - Finalist for Round II competition

American Medical Association

- Redesigning Residency Initiative
  - Finalist for Round II competition

Institute for Healthcare Improvement

- Leadership and Organizing for Change Course
- IHI Open School
  - Completion of *Improvement Capability* (QI 101 to 301)
  - Completion of *Patient Safety* (PS 101 to 204)
  -

Research and Professional Presentations

Provider Adherence to Cervical Cancer Screening in HIV Patient Populations. C. Brett, D. Ahuja, and O. Badmus. Open Forum Infectious Disease, October 2019.

Encyclopedia of Water: Science, Technology, and Society. Chapter: Vibrio Bacteria in Aquatic Ecosystems; Effects of Climate Change on Antibiotic Resistance. Cecile Hart Scott, Catherine Brett. Page 2535-2557. Wiley 2020.

Hypertension and hypertensive disorders of pregnancy in the morbidly obese.

Catherine Brett, MD, MPH

Quality Director, UM/QIO

550 High Street, Suite 1000, Jackson MS 39201

[redacted] [redacted]

https://www.doximity.com/pub/catherine-brett-md

Catherine Brett, MD; Michelle Duncan, MD; Kimberly Hickey, MD. Pregnancy Hypertension: An International Journal of Women's Cardiovascular Health, October 2019

Outbreak Investigation of Enlarged Spleens in a Refugee Population. Division of Acute Disease Epidemiology at the Department of Health and Environmental Control of South Carolina.

- Assisted with chart abstraction of cases and identification of controls; publication in Morbidity and Mortality Weekly Report (MMWR).

Improving Primary Care Access for Residents in Training at Prisma Health.

- Poster Presentation at Prevention 2019, ACPM National Conference, May 2019
- Poster Presentation at Discover USC, April 2019

Human Sexuality in Adulthood

- Lecture for Introduction to Clinical Medicine Course of 1st Year Medical Students at the University of South Carolina Medical School, March 2018

Prevalence of Hypertension and Hypertensive Disorders of Pregnancy in Morbid Obesity

- Poster presentation at XVII ISSHP World Congress, October 2010

Low dose Ganirelix versus Luteal Phase Leuprolide Protocols for In Vitro Fertilization

- Poster presentation at American Society of Reproductive Medicine, October 2005

Professional Memberships

American Medical Association, Member 2000 to present
American Medical Women's Association, Member 2002 to present
American College of Obstetrics and Gynecology, Member 2005 to present
Georgetown Women in Medicine, Member 2006 to present
Medical Society of the District of Columbia, Member 2009 to present
Mississippi State Medical Society, Member 2010 to present
South Carolina Medical Association, Member 2017 to present
American College of Preventive Medicine, Member 2017 to present
American College of Lifestyle Medicine, Member 2019 to present
American Board of Quality Assurance and Utilization Review Physicians, Member 2019 to present

A. KEITH HEARTSILL, CPA, FHFMA

EDUCATION:

University of Alabama, Tuscaloosa, Alabama
1989, Master of Business Administration
University of West Florida, Pensacola, Florida
1979, Bachelor of Arts in Accounting

EXPERIENCE:

November 2014 to Present

MISSISSIPPI DIVISION OF MEDICAID, Jackson, Mississippi
Healthcare Financial Consultant, Owner – Cornerstone Healthcare Financial Consulting, LLC
Responsibilities: Working under contract performing various financial analyses of accounting systems, budgets, provider reimbursement and other financials for the managed care contracts and related services.

August 2012 to November 2014

ANDERSON REGIONAL MEDICAL CENTER, Meridian, Mississippi
A 400 bed general acute-care, private hospital
Chief Financial Officer/VP – Finance
Responsibilities: Oversight of all financial operations for the system and subsidiaries including accounting and audit, financial reporting, budgeting, Revenue Cycle, coding, clinical documentation, case management and materials management. Had seven director level positions reporting to me. Subsidiaries include Anderson Physician Alliance, Anderson Hospital Providers and Anderson Anesthesia Providers. The attached document highlights some significant accomplishments during this tenure.

November 2002 to August 2012

GRENADA LAKE MEDICAL CENTER, Grenada, Mississippi
A 156 bed general acute-care, county hospital
Chief Financial Officer
Responsibilities: Oversight of all financial operations including financial reporting, budgeting, cost reporting, accounts receivable, accounts payable, payroll, medical records, materials management and information systems. Had four director level positions reporting to me.
During my tenure upgraded EHR system to meet meaningful use standards, oversaw financing and building of a new $18,000,000 addition and worked with administration to expand services especially with new physician operations.

April 2000 to November 2002

LANE MEMORIAL HOSPITAL, Zachary, Louisiana
A 135 bed Service District hospital of East Baton Rouge Parish.
Chief Financial Officer
Responsibilities: Same as CFO position at GLMC above.

February 1998 to April 2000

CARRAWAY AFFILIATED HEALTH SERVICES, INC., Birmingham, Alabama, *Controller*
Responsibilities: * Financial oversight of Clinic Operations, Home Health Service, Conference Center and Emergency Physicians Network. Responsibilities include the supervision and financial analysis of monthly financial closings, annual budgeting, forecasting and special analyses for

	twenty-one clinics, clinic home office, Central Billing Office and the other entities. Work with Senior Management in pro-forma preparation for clinics and other new ventures.
July 1997 to January 1998	**MONTEAGLE CORPORATION**, Birmingham, Alabama *Director of Consulting* Responsibilities: * Use of specialized skills and expertise reviewing financial and information management needs of clients. Software products were developed based on this analysis.
February 1990 - July 1997	**METHODIST MEDICAL CENTER**, Jackson, Mississippi A subsidiary of Methodist Health Systems, Memphis, Tennessee *Vice President of Finance* Responsibilities: * Financial oversight of three hospitals, including the main tertiary facility of 409 beds, fifteen physician clinics, and home health agency. * Administrative head of Accounting, Business Office, Medical Records, and Materials Management. Accomplishments: * Reviewed and acquired physician clinics. * Received excellent audit results consistently. * Reduced bad debts while lowering accounts receivable days from 99 to 71. * Achieved excellent JCAHO outcomes in Medical Records by introducing innovative completion policies.
September 1984 - February 1990	**SHELBY MEDICAL CENTER**, Alabaster, Alabama A 210 bed acute care general, county hospital *Assistant Administrator of Finance/CFO* Responsibilities: * Financial operations including General Accounting, Patient Accounting, Medical Records, Data Processing, Purchasing, and Social Services. Accomplishments: * Increased investments from $4 million to $23 million. * Revised investment policy, which assisted improved investment performance. * Wrote RFP, analyzed the market and implemented new hospital wide computer system. * Successfully completed financial feasibility for cardiac cath CON and bond refinancing.
September 1979 - August 1984	**HUMANA, Inc.** Joined Humana right out of college, where I worked in a two-year financial management training program. Progressed through various hospital assignments to the position of Chief Financial Officer, Humana Hospital Enterprise, Enterprise, AL
MEMBERSHIPS AND ASSOCIATIONS:	* Fellow, **Healthcare Financial Management Association** * Member, **American Institute of Certified Public Accountants**

Appendix D: Memorandum of Redactions and Cures

MEMORANDUM

From: The Mississippi Division of Medicaid
Office of Procurement
Date: Wednesday, August 10, 2022
Re: Redactions and Cures
Mississippi Division of Medicaid Coordinated Care Procurement
RFQ: 20211210
RFX: 3150003991

During the course of the Division's review of submissions to RFQ 20211210, Mississippi Division of Medicaid Coordinated Care Procurement, deficiencies with every submission were found. The Office of Procurement and Margaret Middleton, Attorney III for the Division, worked together, along with advice from Office of Personal Service Contract Review (OPSCR), to cure each deficiency to ensure that the fairest, most competitive procurement could be held. This memo was updated throughout the procurement process.

Matters Affecting All Offerors

Provider Contract Templates

4.2.2.2.A.5.: Submit templates of the Offeror's standard Provider contracts.

All Offerors complied with the requirements stated in 4.2.2.2.A.5. However, some Offerors provided more information than initially expected. Offerors falling into this category were incumbents. After review of these contracts, and it was deemed potentially identifying for some Offerors to have so many Mississippi-specific Contracts available for review, especially UnitedHealth Group, which included over 700 pages of contracts with its proposal, many of them Mississippi Medicaid-specific. Additionally, some Offerors included identifying information in their draft contracts, including but not limited to locations of businesses, references to related entities, and references to current CCO Contract sections.

DOM conferred with OPSCR on March 30, 2022, to discuss this issue. In light of that conversation, and in an effort to preserve the sanctity of the blind evaluation process while also allowing all offerors a fair chance to amend their contract submission, DOM emailed all offerors on Monday, April 4, 2022, with the following statement:

> **Clarifying Response requested to 4.2.2.2.A.5, Provider Contract Templates**
> The Office of Procurement asks the Offeror to submit one (1), and only 1, provider contract template as most representative of its contracting practices.
>
> If the Offeror has already submitted a Contract Template that is responsive to this request, inform the Division by response to this email by the deadline, citing the page numbers of that response, pinpointing only one (1) contract and its applicable attachments as they relate to the provider type in the selected contract, if any.

> If the Offeror wishes to make a different submission in response to this request, respond to this email with that one (1) contract and its applicable attachments as they relate to the provider type in the selected contract, if any, in PDF format, by the deadline."

Offerors were instructed to respond to this request by 5:00 p.m., Monday, April 4, 2022. All Offerors responded, and each Qualification was amended by DOM as needed based on those responses.

To explain breaks in pagination due to removal of some contract templates from Technical Qualifications, the Evaluation Committee was given the following instruction:

> Question 4.2.2.2.A.5: Submit templates of the Offeror's standard Provider contracts.
>
> a. The Division's intent was to seek a contract template that was most representative of the Offeror's contracting practices. Some Offerors responded with one contract; some responded with more than one. All Offerors had the opportunity to clarify their provider contract submission and did so. Other draft contracts, if submitted, were excluded. This has caused a break in pagination for some proposals, but it is not an indication of missing information.

Use of the Present Tense

When DOM received proposals, DOM found that Offerors did in some instances speak of partnerships in the present tense. This was deemed to be largely a stylistic writing choice, and there were no instances of identifying information found. TrueCare in particular used the present tense to describe relationships, and while it would be impossible for them to be identified as an incumbent because they are a new entrant into the market, DOM wanted to consult with OPSCR about the issue out of an abundance of caution. DOM discussed this issue with OPSCR on March 30, 2022, asking if an instruction could be given to the Evaluation Committee to disregard use of present tense in discussing partnerships. OPSCR confirmed that was a viable option for handling the issue. Therefore, the Evaluation Committee was given the following instruction:

> Throughout these proposals, Offerors may use the present tense in describing their relationship with the State, the Division, and MSCAN and CHIP members, as well as the statuses of the services that they will provide. The use of these terms, no matter the frequency, should not be regarded as an indicator of incumbency or non-incumbency. The Evaluation Committee should not make inferences from these drafting choices.

Metadata

Each Offeror's Qualification had metadata due to the electronic nature of the proposal. Identifying metadata was wiped from each Technical Qualification before it was given to the Evaluation Committee.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Individual Cures

Documentation of curative activities are included for each offeror, below. Offerors are listed in alphabetical Order, and all page references refer to the paginated page in each Qualification.

Amerigroup Mississippi, Inc.			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took Action**
Transmittal Letter	Amendment 10 required that the Offeror attached a signed Attendance Sheet for the Pre-Qualification Conference. The Offeror did not supply this attachment.	**Action:** DOM emailed the Offeror on Monday, April 4, 2022, seeking the Attendance Sheet no later than 5:00 p.m. that day. **Result:** The Attendance Sheet was received by the stated deadline.	This was a minor informality that could be corrected.
Technical Proposal	There was a phone number (1-800-884-3222) included on page 418 of proposal. When dialed, this phone number did not work correctly.	**Action:** DOM redacted the phone number out of an abundance of caution.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposals	On page 410, an element of the Offeror's work was described as "proprietary" in the Offeror's proposal.	**Action:** DOM redacted the use of the word "proprietary."	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.

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Magnolia Health Plan, Inc.			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took Action**
Transmittal Letter	The DHHS Certification for subcontractor NCH Management Systems, Inc., was difficult to read.	**Action:** DOM emailed the Offeror on Monday, April 4, 2022, seeking clarification 5:00 p.m. that day. **Result:** The exact DHHS Certification as submitted by the subcontractor was sent to DOM by the stated deadline. This response was deemed sufficient.	This was a minor informality that could be corrected.
Transmittal Letter	The DHHS Certification for subcontractor Turning Point Healthcare was difficult to read.	**Action:** DOM emailed the Offeror on Monday, April 4, 2022, seeking the Attendance Sheet no later than 5:00 p.m. that day. **Result:** The exact DHHS Certification as submitted by the subcontractor was sent to DOM by the stated deadline. This response was deemed sufficient.	This was a minor informality that could be corrected.
Technical Proposal	Identifying Information: The Offeror included the name of a subcontractor (Vigilant Health) on the following pages of its proposals: Vigilant/Vigilant Health – pg. 28 (x3) + "in the rural Mississippi Delta"; pg. 111 (x2); pg. 113; pg. 222 (x5) + "in Mississippi"; pg. 238; pg. 258 (x4); pg. 419 (x5) + Mississippi + "in Mississippi"; pg. 477 + "Mississippi-based"; pg. 478 (x3)	**Action**: DOM redacted all appearances of the subcontractor's name and other descriptive characteristics beyond the services to be provided by the subcontractor.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 1, an element of the Offeror's work was described as "proprietary" in the Offeror's proposal.	**Action:** DOM redacted the use of the word "proprietary."	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible. Use of this term is not *de facto* identifying, but it was removed in the stated locations out of an abundance of caution.

Magnolia Health Plan, Inc.			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took Action**
Management Proposal	Section 4.3.4, Management and Control, was not included with the Offeror's proposals	**Action**: DOM emailed the Offeror on Thursday, March 31, 2022, to ask if the Offeror intended to omit this section, and if not, allowing the Offeror to submit the section no later than 2:00 p.m. the same day. **Result**: The Offeror submitted the section before the deadline.	Reasoning is provided in a more narrative format below this table.*

Management Proposal *

Upon review of the Magnolia's Management submission, the Division found that Magnolia's submission did not include Section 4.3.4, Management and Control. This is the final section of the Management submission.

The Division contacted OPSCR on March 11, 2021, seeking guidance. OPSCR was not made aware of the Offeror's identity. The Division was directed to PPRB Rules 3-204.01.3.3, Classifying Proposals and Qualifications, and 3.204.03, Mistakes in Proposals or Qualifications, and additional provisions in the Division's proposal, cited below. OPSCR stated that allowing an opportunity for the Offeror to cure was appropriate based on the OPSCR Rules and the Divisions rules as stated in the RFQ, and that should the Division find that a portion of another Offeror's submission was missing in a similar manner, then the same process for cure should be allowed to that Offeror. The Division agreed that it would use such a process if a similar matter was found.

The Division considered elements of RFQ Sections 1.7, 2.2.4, and 3.2.1, all of which allow for seeking of clarification and waiver of minor informalities. Additionally, the Division considered the following facts in deciding to allow Magnolia to submit Section 4.3.4:

1. The CCO Procurement was the first time the Division used electronic submission to accept procurement submissions, and there could have been an unknown technical issue to both parties;
2. Magnolia cites to a subsection of Section 4.3.4 on Page 1 of its Executive Summary, describing elements that would appear in that section, and thereby indicating an intention to have included Section 4.3.4 with its Management submission.
3. The section in question was to be scored as pass or fail and would not have an affect on the numerical score of the Offeror.

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Molina			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took/did not take Action**
Transmittal Letter	Amendment 10 required that the Offeror attached a signed Attendance Sheet for the Pre-Qualification Conference. The Offeror did not supply this attachment.	**Action:** DOM emailed the Offeror on Monday, April 4, 2022, seeking the Attendance Sheet no later than 5:00 p.m. that day. **Result:** The Attendance Sheet was received by the stated deadline.	This was a minor informality that could be corrected.
Technical Proposal	On page 45, Section B.1.a.: Offeror did not supply a yes/no answer.	**Action:** None. The Offeror did answer that its call center would be in Mississippi. It did not give an address. It described characteristics of the call center that are described within the proposal.	The question could be interpreted to mean that a brief explanation was allowed, making this a minor informality even read in the most restrictive light.
Technical Proposal	On pages 69 – 74 and pages 381 – 387, which are the Offeror's marketing samples, the Offeror did not include anything overtly identifying; however, DOM chose to make redactions for reasons explained in the next column.	**Action:** While the Offeror did not include anything overtly identifying, the curved edges of some of the graphics are possibly identifying as branding, so they were removed in some areas, as were references to Mississippi. Alterations that have no substantive effect on the Offeror's proposal were made out of an abundance of caution.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 93, the Jackson, Mississippi, was referenced as the location of the Provider Services Call Center.	**Action**: The word "Jackson" was redacted. While not specifically identifying, the word was removed out of an abundance of caution.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 212, entitled, "INITIAL CHA SUMMARY," identifying information appeared in the "Contact Information" box. Five phone numbers were included for Member Services, Nurse Advice Line, and BH Line – Crisis Line. Calling the numbers leads to a line that identifies the Offeror.	**Action:** Redacted phone numbers.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 312, the Offeror made reference to tornadoes in "December 2021." A reader with knowledge of the natural disaster could identify this as a reference to the Kentucky tornadoes of	**Action:** Redacted "December 2021"	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.

Molina			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took/did not take Action**
	December 2021, which could be identify the Offeror as a Kentucky plan, and thereby reveal the identity of the Offeror.		
Technical Proposal	On page 379, "Molina Healthcare" appears twice in Exhibit 4: Tightly Managed Process Ensures Timely Completion, in the 4:00 am and 4:30 am boxes.	**Action:** Redacted "Molina Healthcare"	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 388, RxBIN, RxPCN, and RxGRP numbers appears.	**Action:** Numbers redacted.	It is unclear if these numbers would have been identifying, but the redaction has no substantive effect on the Offeror's proposal and was made out to preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 385, "alertline" was mentioned twice.	**Action:** Redacted term	It is unclear if this term would have been identifying, but the redaction has no substantive effect on the Offeror's proposal and was made out to preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On several pages, an element of the Offeror's work was described as "proprietary" in the Offeror's proposal: Pages 27, 31, 42, 133, 167, 173, 238 x2, 244, 245, 287, 348, 358, 361 (x3), 365, 366, 367, 368, 372	**Action:** DOM redacted the use of the word "proprietary."	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible. Use of this term is not *de facto* identifying, but it was removed in the stated locations out of an abundance of caution.

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United Healthcare			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took Action**
Letter of Intent	The Offeror submitted its Letter of Intent (LOI) in Microsoft Word format. The RFQ directed the Offeror to submit the LOI in PDF format.	**Action**: LOI converted to a PDF.	This was a minor informality that could be waived.
Technical Qualification	On pages 71-75, the Offeror's name and identifying information was redacted, but it was still searchable within the PDF.	**Action:** Information redacted.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Qualification	On page 860, the Offeror included the statement, "*Division Required Question in BOLD," which would indicate that the Offeror is an incumbent.	**Action:** Information redacted.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Qualification	On page 1026, the bottom of a letter for the website could be viewed.	**Action:** Information redacted.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible. While this may not have been identifying, redaction has no substantive effect on the Offeror's proposal was made out of an abundance of caution.
Technical Qualification	On pages 1127 and 1129, the Offeror stated that project would show results "by the end of 2022," which may indicate that the Offeror is an incumbent.	**Action:** Phrase "by the end of 2022" redacted	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible. While this may not have been identifying, redaction has no substantive effect on the Offeror's proposal was made out of an abundance of caution.
Technical Qualification	In the Offeror's Provider Contract Template, the Offeror included potentially identifying information: • Page 392: The Offeror noted "Effective July 1, 2014" which could indicate that the Offeror is an incumbent. • The Offeror included a link to Portal.com on pages 346, 350, and 370 (x2) • On page 404, the Offeror included the parenthetical, "(who meet requirements of Section 4.B, Choice of a Health Care Professional)" – This is a reference to the current MSDOM CCO Contract, which could identify the Offeror as an incumbent.	**Action:** Information redacted.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible. While this may not have been identifying, redaction has no substantive effect on the Offeror's proposal was made out of an abundance of caution.

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TrueCare			
Location of Issue	**Description of Issue**	**Action Taken by DOM/Result of Action (if applicable)**	**Reason DOM took Action**
Technical Proposal	On page 54, in Figure 4.2.2.1_G Text Messaging, a URL appears in the graphic: http://mp0.co/unvaB. This URL leads to a CareSource website when typed into a browser. The same appeared on page 383 in Figure 4.2.2.11_A.	**Action:** DOM redacted the URL on both pages.	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On page 152, Madison County and Mississippi appear. Naming of these locations could identify the offeror.	**Action:** DOM redacted both "Madison County" and "Mississippi"	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible.
Technical Proposal	On several pages, an element of the Offeror's work was described as "proprietary" in the Offeror's proposal: Pages 221, 257, 263	**Action:** DOM redacted the use of the word "proprietary."	To preserve the integrity of the blind scoring process while also ensuring that as many responsive offers made it to the Evaluation Committee as possible. Use of this term is not *de facto* identifying, but it was removed in the stated locations out of an abundance of caution.
Management Proposal	TrueCare's submission for 4.3.4, Management and control, used font smaller than that required by the RFQ. The Division converted 4.3.4 to Word and changed the font sizes to the required sizes in the RFQ. By making alterations for space not used by True Care on some pages of its 4.3.4 submission, the content fit within the format parameters with the bigger, required font sizes. No further action was needed.		This was a minor informality that could be waved.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

[END OF MEMORANDUM]

Appendix E: Evaluation Committee Member Attestation Regarding Technical Evaluation and Materials

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

EVALUATION COMMITTEE MEMBER ATTESTATION REGARDING TECHNICAL EVALUATION AND SCORING MATERIALS

As a member the Evaluation Committee for the Division of Medicaid's (DOM) Coordinated Care Organization Procurement, I signed the following documents through Docusign after the conclusion of the Technical (Blind) Evaluation and Scoring for the aforementioned procurement, certifying the Consensus Scores:

- Evaluation Round 1: Technical Factors – Blind Scoring Consensus – Offeror A
- Evaluation Round 1: Technical Factors – Blind Scoring Consensus – Offeror B
- Evaluation Round 1: Technical Factors – Blind Scoring Consensus – Offeror C
- Evaluation Round 1: Technical Factors – Blind Scoring Consensus – Offeror D
- Evaluation Round 1: Technical Factors – Blind Scoring Consensus – Offeror E

I attest and affirm that I will not access the aforementioned documents for the duration of the Management Evaluation and Scoring period of DOM's Coordinated Care Procurement, nor will I seek to access any other documents containing Consensus scores or comments pertaining to the Technical (Blind) Evaluation and Scoring for the aforementioned procurement (should such documents exist), until such time as the Management Evaluation and Scoring period for the aforementioned procurement is concluded. When the Management and Evaluation Scoring period is concluded, I will access the aforementioned documents in order to prepare the Evaluation Committee's final report.

I further attest and affirm that I will not access any materials from the Technical Evaluation and Scoring period, including but not limited to the proposals themselves and any comments or notes in my possession, until such time as the Management Evaluation and Scoring period for the aforementioned procurement is concluded. When the Management and Evaluation Scoring period is concluded, I will access the aforementioned documents in order to prepare the Evaluation Committee's final report.

Sam Atkinson	Deputy Administrator, Accountability and Compliance
Name (Printed)	Title
Samantha Atkinson	6/13/2022 | 9:41:57 AM CDT
Signature	Date

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

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Catherine Brett	Quality Director
Name (Printed)	Title
Catherine Brett	6/13/2022 | 2:27:38 PM CDT
Signature	Date

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

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Jennifer Grant	Benefit Program Manager
Name (Printed)	Title
Jennifer Grant	6/14/2022 | 2:54:22 PM CDT
Signature	Date

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

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Keith Heartsill	Healthcare Financial Consultant
Name (Printed)	Title
Keith Heartsill	6/13/2022 | 11:00:39 AM CDT
Signature	Date

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

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Sharon Jones	DOM Special Projects Administrator
Name (Printed)	Title
Sharon Jones	6/14/2022 | 11:43:18 AM CDT
Signature	Date

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

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Evelyn Sampson	Lead IT Project Manager
Name (Printed)	Title
Evelyn Sampson	6/13/2022 | 10:51:22 AM CDT
Signature	Date

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

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Jennifer Wentworth	Deputy Administrator
Name (Printed)	Title
Jennifer Wentworth	6/13/2022 | 10:08:05 AM CDT
Signature	Date

Appendix F: Petition for Relief

Public Procurement Review Board
Office of Personal Service Contract Review
Form PPRB-003 Revised January 1, 2020

PETITION FOR RELIEF FROM BIDDING AS A PROCUREMENT METHOD (INDEPENDENT CONTRACTOR)

Agency: Office of the Governor, Division of Medicaid
Agency Contact Name: Kayla McKnight
Agency Contact Email Address: kayla.mcknight@medicaid.ms.gov
Agency Contact Phone Number: 601.359.2286
Date Form Submitted to PPRB's OPSCR staff: May 5, 2021
Requested PPRB Meeting Date: June 2, 2021
Briefly describe the proposed scope of work for the procurement:

The State of Mississippi, Office of the Governor, Division of Medicaid (DOM) issues this Request for Qualifications (RFQ) to solicit offers from responsible offerors to provide services for statewide administration of the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program that serves eligible children and adults in Mississippi, and the Mississippi Children's Health Insurance Program (CHIP), a coordinated care program for Mississippi children. Both programs were implemented to address the following goals: improve access to needed medical services, improve quality of care, and improve efficiencies and cost effectiveness. DOM is seeking to contract for these services jointly for the first time, as recently approved by the state legislature. DOM is also seeking a waiver of PPRB rules, specifically the five-year limitation on contracts. DOM is requesting that PPRB allow DOM to use a term of four years with option of two one-year renewals. The RFQ will result in the award of no fewer than two (2) and no more than three (3) contracts.

---

1. Petition for relief from bidding (the use of Invitation for Bids) as a procurement method may be requested for one of the reasons listed below. Check the reason that prevents your agency from using Invitation for Bids (IFB) as a procurement method for this service:

   ☐ Federal and/or state law has established limitations on the use of competitive bidding for the personal or professional contracts the agency is seeking to procure;
   ☐ The agency is required to hire professionals whose members are prohibited from bidding by the rules of professional conduct promulgated by the regulating agency or agencies for that professional; or
   X Competitive bidding through the use of an Invitation for Bids (IFB) is not practicable and advantageous to the business of the agency.

2. Provide a detailed explanation of the reason(s) why a procurement method other than bidding (IFB) is requested (attach supporting documentation including, but not limited to, any identified laws, orders, rules, or regulations issued by a governing body):

Program Summaries

Medicaid Overview

As part of the Social Security Amendments of 1965, Medicaid was created to provide health coverage for certain eligible, low-income populations. In 1969, Mississippi Medicaid was authorized by the State Legislature. The Division of Medicaid in the Office of the Governor (DOM) is the sole agency responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP). The mission of DOM is to responsibly provide access to quality health coverage for vulnerable Mississippians, and doing so with the stated values of accountability, consistency, and respect.

MississippiCAN

DOM implemented the Mississippi Coordinated Access Network (MississippiCAN) Program for selected high-risk beneficiaries on Jan. 1, 2011, as authorized by the State Legislature. Additional information can be found at https://medicaid.ms.gov/programs/managed-care/. Since 2011, the MississippiCAN population has been expanded to include the following:

Table 1. Populations Who Have the Option to Enroll

Populations Who Have the Option to Enroll	Age Categories*
SSI	0-19
Disabled Child Living at Home	0-19
DHS-Foster Care Children	0-19
DHS-Foster Care Children (Adoption Assistance)	0-19
America Indians	0-65
**The hyphen denotes "up to" the age listed.*	

Table 2. Populations Who May Not Disenroll

Populations Who May not Disenroll	Age Categories*
SSI	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Pregnant Women	8-65
Parent/Caretakers	19-65
Medical Assistance Children (Populations other than those listed in Table 1)	0-19
**The hyphen denotes "up to" the age listed.*	

The MississippiCAN population will also encompass any additional populations as authorized by state law during the life of the contract.

CHIP

The Federal Children's Health Insurance Program (CHIP) was established under Title XXI of the Social Security Act. The CHIP program is designed to provide health coverage to children in families with incomes too high to qualify for Medicaid but unable to afford private coverage. Mississippi's CHIP was established by Miss. Code Ann. § 41-86-1, *et seq.* (1972, as amended). The State and School Employees' Health Insurance Management Board (HIMB) historically administered CHIP; however, effective January 1, 2013, the CHIP program and the contract for insurance services were transferred from the HIMB to DOM through Miss. Code Ann. § 41-86-9 (1972, as amended). DOM is currently responsible for the implementation and administration of CHIP in accordance with Federal and State laws. Additional information about Mississippi's CHIP program can be found at: http://www.medicaid.ms.gov/programs/childrens-health-insurance-program-chip/. The following populations are eligible for coverage under CHIP:

Table 3. Populations Who Are Eligible for CHIP

Populations	Income Level
Birth to Age One (1) Year	194% FPL to 209% FPL
Ages One (1) to Six (6) Years	133% FPL to 209% FPL
Age Six (6) to Nineteen (19) Years	133% FPL to 209% FPL
FPL = Federal Poverty Level	

Joint Administration

These two programs are being procured together for the first time, as authorized under SB2799, 2021 Mississippi Legislative Session, amending Miss. Code Ann. § 41-13-117(H)(2). Jointly procuring and administrating the programs relieves administrative burden, both for providers and the state, and it allows oversight to be consolidated for ease and clarity. Vendors will be expected to deliver services and handle requirements for both programs, administrating them concurrently. They will have to follow requirements and deliver services laid out in the Mississippi Medicaid State Plan and the Mississippi CHIP State Health Plan. Some of the services and requirements are different, and vendors must be able to be attentive of those differences and administrate the programs accordingly.

Joint administration is also useful because both programs are very similar in application, and both are designed to meet the following goals:

- Improve access to necessary medical services by connecting beneficiaries with a medical home, increasing access to health-care providers, and improving beneficiaries' use of primary and preventive care services.
- Improve quality of care and population health by providing systems and supportive services, including care coordination, care management, and other programs that allow beneficiaries to take increased responsibility for their health care.

- Improve efficiencies and cost effectiveness by contracting with entities on a full-risk prepaid capitated basis to provide comprehensive services through an efficient, cost-effective system of care.

Combining the CHIP and MSCAN populations for joint administration will make the contract more attractive for offerors, hopefully increasing the number/quality of bids for both populations.

Combining the contracts and their administration both increases the likely number/quality of plans to bid on both programs generally, and especially for CHIP.

RFQ is the Best Procurement Method

DOM is requesting to competitively procure for MSCAN and CHIP services through a RFQ for two reasons:

1. Price is not an evaluation factor in the procurement. Vendors will be paid a capitated rate that is formulated by an actuarial firm. A RFQ is the appropriate vehicle for evaluation of the needed services.
2. The evaluation factors consider the relative abilities of offerors to perform, including degrees of technical and professional experience and expertise. Evaluation will be conducted by subject matter experts who will render scores based on the unique policies, procedures, and program designs of the competitors.

Previously, the MississippiCAN procurement has been sought through a Request for Proposals (RFP). CHIP was more recently procured than MississippiCAN, and an RFQ method was used. Based on the above, DOM requests PPRB allow the procurement to be conducted through an RFQ.

3. If petition for relief from bidding is granted, a competitive procurement procedure for selecting the vendor must be established. The PPRB may audit your records to ensure competitive procedures were used to procure the required service. If the request for petition for relief from bidding (IFB) is granted, please indicate the method of procurement that will be used:

   ☐ Request for Proposals
   X Request for Qualifications
   ☐ Other (Please explain):

4. When will the procurement be issued and/or advertised?
   June 4, 2021

5. When will the vendor(s) be selected?
   November 12, 2021

6. How many contract(s) will be issued as a result of the procurement?

No fewer than two (2) and no more than three (3).

7. What evaluation factors will be used and what is the weight/percentage of each factor?

DOM requests permission to us use a 1000-point scale to evaluate qualifications. PPRB Rule 3-204.01.3.1 Evaluation Scoring states that a 100-point scale is required. However, due to the extremely detailed nature of this procurement, having a higher-point scale creates the opportunity for more accurate weighting of questions as well of ease and ensuring the accuracy of tabulation.

QUALIFICATION SECTION	MAXIMUM SCORE	TECHNICAL/MANAGEMENT
Transmittal Letter	Pass/Fail	Reviewed by the Office of Procurement
Executive Summary	Pass/Fail	Technical Factors (Phase 1 unmarked)
Methodology Work Questionnaire (including Work Plan and Schedule)	340	Technical Factors (Phase 1 unmarked)
Innovation and Commitment	110	Technical Factors (Phase 1 unmarked)
Corporate Background and Experience	100	Management Factors (Phase 2)
Ownership and Financial Disclosure Information	Pass/Fail	Management Factors (Phase 2)
Organization and Staffing	100	Management Factors (Phase 2)
Management and Control	Pass/Fail	Management Factors (Phase 2)
Price	350	Same score for all*
TOTAL	**1000**	

*See 3-204.01.3.2 Determination of Price in Requests for Qualifications. Because DOM sets the price, all offerors will receive the same score – the maximum of 350.

Technical Factors (Phase 1 of Evaluation)
During Phase 1, the Evaluation Committee will have access to the Executive Summaries of each offeror, as well as each offeror's Methodology Work Questionnaire (MWQ) and Innovation and Commitment plans.

The MWQ includes but is not limited to the following areas:

- Eligibility, Enrollment, and Disenrollment
- Financial Data and Reporting
- Member Services and Benefits
- Provider Services and Network
- Quality and Utilization Management
- Information Technology
- Subrogation and Third-Party Liability
- Program Integrity
- Subcontractual Relationship and Delegation
- Care Management

The Innovation and Commitment section will assess the offerors' proposals for novel and creative ways to improve services and service delivery, including but not limited to proposed value-based purchasing models, value adds, performance improvement projects, utilization of technology, and modes of improving health literacy. Additionally, the offerors will have to explain their commitment to these areas by articulating expected job and financial investments for their proposals, clearly stating the methods by which their innovations will be implemented.

After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.

The **innovation** aspect asks Offerors submit to overviews of their plans for the following new and/or improved aspects of the Contract; the **commitment** aspect assesses the details of how the Offeror will deliver on their plan, including financial and human capital investment. Service delivery areas being assessed are:

- Care Management
- Value-Based Purchasing
- Patient-Centered Medical Homes
- Social Determinants of Health
- Value-Adds
- Performance Improvement Projects
- Health Literacy Campaigns
- Telehealth
- Use of Technology
- Proposed Partnerships

DOM will evaluate each area based on the value to MississippiCAN and CHIP Members of the work proposed and the value to the state.

Management Factors (Phase 2 of Evaluation)

This phase looks largely at the offeror's ability to deliver on the work promised under the assertions made in the Technical Factors materials. The Management Phase will be the Division's assessment of whether the Offeror has the ability to deliver on those services. The following include considerations for the Evaluation Committee during assessment of the Management Factors:

- **Corporate Background and Experience**: Does the offeror have experience with the work necessary to the contract? Does the offeror have a history of ethical violations or sanctions? What is the philosophy of the organization, and how has that translated into its previous deliveries of services?
- **Ownership and Financial Disclosure Information**: Are there any conflicts that come up because of the ownership of the offeror? Is the ownership stable and reputable? Are the offeror and any ownership companies financially stable and properly capitalized to perform the work both well and without interruption of services?
- **Organization and Staffing**: Does the offeror have sufficient staff to perform the work? Is the organization stable and able have the necessary structure to ensure that stability? Does the organization place an emphasis on cultural competency relevant to the MississippiCAN and CHIP populations and cultural sensitivity in the hiring of its own staff?
- **Management and Control**: What are the offeror's proposed performance standards, and how does the offeror manage those? How does the offeror assess risks and manage them? How does the offeror set milestones, and how does it define success in meeting them?

8. What is the anticipated term of the contract?

DOM requests the extension of the term of the contract by one year, making the contract a maximum of six years total. The initial term would be four years, with the option of two one-year extensions. Historically, this contract is limited to five years per PPRB rules. However, due to the nature of the contract, waiver of the PPRB rule is in the best interest of Medicaid CCO members and the state.

The contract has a necessarily protracted implementation period. The previous contract's implementation period lasted about a year and a half, and it is anticipated that this cycle's contract will require the same period. Implementation requires intense collaboration between DOM and winning vendors to ensure that all information technology systems are compatible and running, quality metrics are clear and sufficient investment has been made by the vendors to make them achievable, and that vendors have the appropriate staff in place in the state to ensure that members receive the services they have been promised. The implementation period is a no-cost period of the contract.

Under the five-year limitation, only three-and-a-half years remain for the operational part of the contract after completion of the implementation period. The brevity of this period has a significant impact on both measurement of success of quality initiatives and metrics and on the next procurement cycle. The procurement cycle takes about two years, from inception to completion, and overlaps with the current contract cycle. That means that it must start no later

than a year-and-a-half into the current contract's operational period. This puts DOM and the state at a disadvantage in adjusting a future procurement to seek proposals that would represent a true improvement to the managed care system in Mississippi because the policies and procedures of current-cycle plans would have only had a base year of measurement to get quality improvement initiatives off the ground.

By having the ability to start the procurement cycle after two-and-a-half years of operationality, DOM can assess both a base year and a measurement year for quality initiatives, meaning it can adjust its procurement to seek plans that might better fit for Mississippi Medicaid CCO Members' needs. Doing so would also be expected to have benefits for the state budget; if DOM can find plans that increase the quality of the services delivered, and therefore produce better health overall for the Medicaid CCO population, then that could result in an overall savings in expenditures on Medicaid CCO services.

An additional year for the contract would allow DOM the ability to ensure that Members and the state are getting the best out of winning plans. DOM respectfully requests that PPRB grant a waiver of the five-year limitation.

There are **two main reasons** that Members and the state would greatly benefit from an additional contract year:

Assessment

Having the additional year for measurement of programs gives the Division another year of data to assess, ensuring the Division has a baseline measurement year and a measurement year before the procurement cycle begins. As it currently stands, the internal procurement process must begin before a measurement year can be completed, which leaves the Division at a disadvantage in defining priorities for the next-cycle procurement. The current five-year limitation also gives the Division less time to figure out of the vendors' investments in quality are working. A great emphasis has been placed on improving quality in the next contract, and giving the vendors an extra year of investment and time to implement their plans would let the Division know:

1. Are Members truly getting better service delivery?
2. Is the state truly getting value out of the vendor and the delivery model?

These questions are symbiotic – if Members can get better service delivery, that should mean that they are getting better care, and lead to improved health outcomes. If health outcomes are improved, then that should lead to better quality of life in the state and lower Medicaid costs under the state's budget.

Under the five-year model, assessment time is limited because the vendors functionally have three-and-a-half years to execute their plans. An extra year give both the Division and the vendors time to really make those plans work, and it would give the Division additional time to understand what improvements in service delivery the Division should seek in future procurement cycles.

Quality of Bids

Mississippi is a smaller state by comparison to others. The combination of that population (and therefore the smaller available Medicaid population) with a contract that functionally only pays for three-and-a-half years of services limits the state's ability to get more/better quality bids. By adding an additional year to the contract, the procurement could attract more interest from more vendors. The longer payment period of the contract could make the infrastructural investment needed to make a plan successful and worth it for more potential vendors.

If PPRB decides not to grant the waiver, then DOM wishes to pursue a three-year contract with two one-year extensions, as usual.

9. Will the contract include renewal terms? If yes, how many?
   There will be two (2) one-year renewal terms, no matter if the initial term is three or four years.

10. What is the anticipated total amount of funds expended under the contract?
    Total SFY 2020 expenditures were $3,101,046,945 (All three current MSCAN contracts: $2,938,409,911 and both CHIP current contracts: $162,637,034).

11. Will the contract negate the need for an existing PIN/WIN? If so, please explain how the contract is more cost effective:
    No.

12. Please indicate whether procurement is associated with any new, continued, expanded, or terminated program(s):
    This procurement is associated with the continuation of the MississippiCAN and CHIP programs. These two programs are being procured jointly for the first time pursuant to SB2799, 2021 Mississippi Legislative Session, amending Miss. Code Ann. § 41-13-117(H)(2).

13. Please provide the names of the Evaluation Committee members.
    Jennifer Wentworth
    Keith Heartsill
    Jennifer Grant
    Sharon Jones
    Dr. Catherine Brett
    Shenetta Drone
    Samantha Atkinson

14. Has relief from bidding of this service been previously requested? ☐ No X Yes

PETITION FOR RELIEF FROM BIDDING AS A PROCUREMENT METHOD (INDEPENDENT CONTRACTOR)

MSCAN and CHIP have both previously been permitted to use RFP and RFQ processes for the reasons stated in previous questions. The RFP for the MSCAN was procured prior to the Petition for Relief requirement and did not require approval from the Board. CHIP was procured through RFQ and was approved by PPRB on April 4, 2018. Previous approval for CHIP is attached.

_____ _____

Chief Procurement Officer Signature Date

Appendix G: Evaluation Committee Member Conflict of Interest Statements

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Sam Atkinson

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

(1) The employee or any member of the employee's immediate family[1] has a financial interest pertaining to the procurement;

(2) A business or organization in which the employee, or any member of the employee's immediate family, has a financial interest pertaining to the procurement; or,

(3) Any other person, business, or organization with whom the employee or any member of the employee's immediate family is negotiating or has an arrangement concerning prospective employment is involved in the procurement.

I hereby certify that I have reviewed the conflict of interest standards prescribed herein, and that I do not have a conflict of interest with respect to the evaluation of this proposal. I

[1] Immediate family is defined as spouse, parent, stepparent, sibling, child, stepchild, grandchild, grandparent, son- or daughter-in-law, mother- or father-in-law or brother- or sister-in-law. Child means a biological, adopted or foster child, or a child for whom the individual stands or stood in loco parentis.

further certify that I am not engaged in any negotiations or arrangements for prospective employment or association with any of the below Offerors submitting proposals or their parent or subsidiary organization.

Offerors submitting Proposals:

1. Amerigroup Mississippi, Inc.
2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Samantha Atkinson
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Sam Atkinson
Title: Procurement Director	Title: Deputy Administrator, Accountability and Compliance
Date: 3/31/2022 | 8:45:38 AM CDT	Date: 3/28/2022 | 3:43:24 PM CDT

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Catherine Brett

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

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Offerors submitting Proposals:

1. Amerigroup Mississippi, Inc.
2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Catherine Brett
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Catherine Brett
Title: Procurement Director	Title: Quality Director
Date: 3/31/2022 | 8:42:21 AM CDT	Date: 3/31/2022 | 8:39:33 AM CDT

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Jennifer Grant

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

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Offerors submitting Proposals:

1. Amerigroup Mississippi, Inc.
2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Jennifer Grant
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Jennifer Grant
Title: Procurement Director	Title: Benefit Program Manager
Date: 3/31/2022 | 8:47:06 AM CDT	Date: 3/28/2022 | 3:35:46 PM CDT

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Keith Heartsill

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

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Offerors submitting Proposals:

1. Amerigroup Mississippi, Inc.
2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Keith Heartsill
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Keith Heartsill
Title: Procurement Director	Title: Healthcare Financial Consultant
Date: 3/31/2022 | 8:46:18 AM CDT	Date: 3/28/2022 | 3:41:48 PM CDT

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Sharon Jones

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

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(3) Any other person, business, or organization with whom the employee or any member of the employee's immediate family is negotiating or has an arrangement concerning prospective employment is involved in the procurement.

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2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Sharon Jones
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Sharon Jones
Title: Procurement Director	Title: DOM Special Projects Administrator
Date: 3/31/2022 | 8:48:12 AM CDT	Date: 3/28/2022 | 3:34:06 PM CDT

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Evelyn Sampson

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

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2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Evelyn Sampson
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Evelyn Sampson
Title: Procurement Director	Title: Lead IT Project Manager
Date: 4/18/2022 | 3:44:24 PM CDT	Date: 4/18/2022 | 3:17:23 PM CDT

Mississippi Division of Medicaid Coordinated Care
RFQ # 20211210
RFx # 3150003991
CONFLICT OF INTEREST AGREEMENT BETWEEN
OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID (DOM)
AND

Jennifer Wentworth

The members of the evaluation committee shall have no personal, financial or familial interest in any of the contract Offerors, or principals thereof, to be evaluated. It shall be a breach of ethical standards for any employee to participate directly or indirectly in a procurement process when the employee knows that:

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2. Magnolia Health Plan, Inc.
3. Mississippi True d/b/a TrueCare
4. Molina Healthcare of Mississippi, Inc.
5. UnitedHealthcare of Mississippi, Inc.

IN WITNESS WHEREOF, this Conflict of Interest Agreement shall be effective as of the date this Agreement.

By: Kayla Mcknight	By: Jennifer Wentworth
Authorized Signature	Participant Signature
Printed Name: Kayla Mcknight	Printed Name: Jennifer Wentworth
Title: Procurement Director	Title: Deputy Administrator
Date: 3/31/2022 | 8:44:13 AM CDT	Date: 3/28/2022 | 4:23:57 PM CDT