

Minnesota Department of Human Services Purchasing and Service Delivery Division

Request for Proposals (RFP) for a Grantee to:

Provide prepaid health care services to eligible individuals through the Special Needs BasicCare and Integrated Special Needs BasicCare contracts throughout 87 counties of the State of Minnesota.

Date of Publication in State Register: October 25, 2021.

Minnesota's Commitment to Diversity and Inclusion:

It is State of Minnesota policy to ensure equity, diversity and inclusion in making competitive grant awards. See Executive Order [19.01](#).

The Policy on Rating Criteria for Competitive Grant Review establishes the expectation that grant programs intentionally identify how the grant serves diverse populations, especially populations experiencing inequities and/or disparities. See [OGM Policy 08-02](#).

Americans with Disabilities Act (ADA) Statement:

This information is available in accessible formats for people with disabilities by calling 651-431-3612 or by using your preferred relay service. For other information on disability rights and protections, contact your agency's Americans with Disabilities Act (ADA) coordinator.

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Request for Proposal - Summary of Important Dates

State Register Notice/RFP Published on DHS Website – October 25, 2021

Questions Due for Responders' Conference – November 19, 2021

Registration for Responders' Conference Deadline – November 19, 2021

Responders' Conference – December 3, 2021

Final RFP Questions Due – December 30, 2021

All RFP Questions Answered and Posted on DHS Website – January 20, 2022

Complete RFP Proposals Due – February 18, 2022

Readiness Review (if applicable) – May - September 2022

Notice of Intent to Contract – Anticipated May 9, 2022

MIPPA Submission to CMS – July 5, 2022

Contract Negotiations – August and September 2022

Start of Contract – January 1, 2023

State Contact: Ms. Kristi Burt at SNP_RFPs@state.mn.us

1. INTRODUCTION

1.1 Objective of RFP

The Minnesota Department of Human Services (DHS), through its Purchasing and Service Delivery (PSD) Division (State), is seeking Proposals from qualified Responders to provide prepaid health care services to people with disabilities age 18 to 64 who are enrolled in Medical Assistance under Special Needs BasicCare (SNBC) and Integrated Special Needs BasicCare (Integrated SNBC) programs throughout Minnesota. This Request for Proposals applies to all 87 counties in Minnesota. Responders that provide Integrated SNBC in a county must also provide SNBC in the same county in order to assure a seamless transition of enrollee choice. Responders may provide SNBC as a standalone product in a county if not currently providing Integrated SNBC in that county.

The term of any resulting contract to provide services under Integrated SNBC and SNBC (Integrated SNBC/SNBC contract) is anticipated to be for one (1) year, from January 1, 2023 until December 31, 2023. Thereafter, the State may choose to renew any contract awarded under this RFP annually for up to five (5) years (in accordance with Minnesota Statutes, section 16B.98 subdivision (5)(b)). The State reserves the right to initiate a new procurement

This Request for Proposals does not include procurement for the Families and Children Medical Assistance (Families and Children), MinnesotaCare, Minnesota Senior Care Plus or Minnesota Senior Health Options. Currently there is a separate RFP issued for Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO). Responders interested in the MSC+ and MSHO RFP must submit a separate proposal.

If responding to both the MSHO/MSC+ RFP and the Integrated SNBC/SNBC RFP and a response to a specific RFP question or Appendix is the same for both, then the Responder should include the same response in each proposal. The Responder cannot reference the other RFP in place of a response. Responding with the phrase "See other RFP" is not an acceptable response.

All Responders must meet the requirements as referenced in section 1.3 (7) Qualified Responders. Currently contracted Managed Care Organizations (MCOs) for the SNBC contract must respond to this RFP in order to be considered for selection to continue providing benefits through the Integrated SNBC and SNBC programs.

People participating in managed care for people with disabilities have an average of more than 5 serious medical conditions per person. Pursuant to Minnesota Statutes, section 256b.69, subdivision 28 and due to the importance of continuity of care, especially for people with high medical needs, Responders who are currently operating SNBC or Integrated SNBC and SNBC in a county will be selected to participate if they meet the minimum requirements of this RFP. Additional Responders may be selected to participate based on scoring and county preferences and if the Responders meet the minimum requirements of this RFP. To serve the above populations in these counties, a Responder must be selected to contract with the State, and complete contract negotiations with the State. All contracts to provide these services are also contingent on successfully passing the Readiness Review, consistent with Minn. Stat. § 256b.6926, subd. 2. DHS does not intend to contract with only one Responder in a county unless the Responder: (1) is currently a plan offered in the county, (2) is the highest scoring Responder in this RFP for the county,

and (3) is the only plan currently serving the county that meets the minimum requirements of this RFP and passes a Readiness Review.

1.2 Proposal Due Date

Proposals must be submitted by 4:00 p.m. Central Time on February 18, 2022. This Request for Proposal (RFP) does not obligate the State to award a contract or complete the project, and the State reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by Responder.

1.3 Background

1. General

Under the authority of Minnesota Statutes, section 256B.69, subdivision 28, the State is soliciting proposals for provision of specified health care services in all 87 counties to serve people enrolled in SNBC and Integrated SNBC.

2. Managed Care Enrollment Process

Responders contracted by the State under this RFP will be offered for managed care enrollment effective January 1, 2023. This includes being offered as a health plan choice in the Annual Health Plan Selection (AHPS) during October 2022 with an effective managed care enrollment date of January 1, 2023.

3. Eligible Populations

- a) **Service Area.** Only those eligible persons who are enrolled in Medical Assistance residing within the counties of the State of Minnesota, as approved as a service area under contract with the MCO, shall be eligible for enrollment.
- b) **Eligible Persons.** Any Recipient of Medical Assistance who resides within the Service Area and meets the criteria outlined below may enroll in the MCO at any time during the duration of the Contract, subject to the limitations contained in the Contract and, if applicable, Medicare enrollment limitations.
- c) **Eligibility/Presumptive Eligibility Determinations.** Eligibility/presumptive eligibility for Medical Assistance will be determined by the Local Agency, and any other entity designated by the State to make eligibility/presumptive eligibility determinations. Eligibility for Medicare will be determined by CMS.
- d) **SNBC Eligibility Determinations.** Under Minnesota Statutes, section 256B.69, subdivision 28 adults and children with disabilities who receive Medical Assistance are assigned to SNBC unless the individual chooses to opt out of enrollment. "Disability" is defined in the SNBC Model Contract as either being certified as having a disability through the Social Security Administration (SSA) or the State Medical Review Team (SMRT), or a person with Developmental Disability for the purposes of the developmental disability waiver, as determined by the Local Agency.

- e) At this time, only adults between the ages of 18 and 64 are being enrolled into SNBC. Enrollment remains voluntary, but eligible people must notify DHS of their intent to opt out of enrollment prior to the effective date of their enrollment. Eligible people have the choice to enroll each month. SNBC enrollees enrolled in the Medicaid-only portion of SNBC may disenroll at any time, effective the end of the month. In order to be eligible for Integrated SNBC, the Recipient must also be eligible for Medicare Parts A and B. Integrated SNBC may disenroll at any time, effective the end of the month, subject to the limitations of the Medicare Special Enrollment Period regulations.
- f) Spenddown. Enrollees who are enrolled into SNBC or Integrated SNBC prior to acquiring a Medical Spenddown are not required to disenroll provided the Enrollee agrees to pay the Medical Spenddown to the State on a monthly basis. Until further notice, the STATE is not currently enrolling new Enrollees who have Medical Spenddowns into SNBC or Integrated SNBC. The only exception is for individuals residing in a nursing facility and coded with a Medical Spenddown because they have elected Hospice.

4. Excluded Populations

The following Medical Assistance eligible beneficiaries are excluded from enrollment in Special Needs BasicCare and Integrated Special Needs BasicCare:

1. Beneficiaries eligible for the Refugee Assistance Program pursuant to [8 U.S.C. §1522\(e\)](#).
2. Persons up to eighteen (18) years of age, or sixty-five (65) years of age and over. Enrollees who turn sixty-five (65) will no longer remain enrolled in SNBC.
3. Beneficiaries who are residents of state regional treatment centers or a state-owned long term care facility.
4. Beneficiaries who are eligible while receiving care and services from a non-profit center established to serve victims of torture.
5. Beneficiaries eligible for the emergency Medical Assistance program.
6. Non-citizen Beneficiaries who only receive emergency medical assistance under Minnesota Statutes, [section 256B.06, subdivision 4](#).
7. Women receiving Medical Assistance through the Breast and Cervical Cancer Control Program.
8. Persons eligible for the Minnesota Family Planning Program (MFPP) in accordance with Minnesota Statutes, section 256B.78.
9. Beneficiaries, who at the time of notification of enrollment in managed care, have a communicable disease whose prognosis is terminal and whose primary physician is not a Network Provider in the MCO, and that physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.
10. Beneficiaries who are terminally ill as defined in Minnesota Rules, part 9505.0297, subpart 2, item N (hospice) and who, at the time enrollment in SNBC would occur, have an established relationship with a primary physician who is not a Network Provider in the SNBC MCO.
11. Beneficiaries with private health care coverage through a HMO certified under Minnesota Statutes, Chapter 62D, not including Medicare Supplements.

12. Beneficiaries with cost effective employer-sponsored private health care coverage, or who are enrolled in a non-Medicare individual health plan determined to be cost-effective according to Minnesota Statutes, [section 256B.69, subdivision 4 \(b\)\(9\)](#).
13. Enrollees who are absent from Minnesota for more than thirty (30) consecutive days but who are still deemed a resident of Minnesota by the STATE. Covered services for these Enrollees are paid by fee-for-service.
14. Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in [§ 1905\(p\)](#) of the SSA, 42 U.S.C. § 1396d(p), and who are not otherwise eligible for Medical Assistance.
15. Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB), as defined in [§ 1905\(p\)](#) of the SSA, 42 U.S.C. §1396a(a)(10)(E)(iii) and §1396d(p), and who are not otherwise eligible for Medical Assistance.
16. Persons who are eligible for Medicare Part A only, or Medicare Part B only.
17. Incarcerated persons; see Minnesota Statutes, section 256B.055, subdivision 14.

5. Financial Considerations

Responders contracted with the State will be paid a fixed monthly payment per enrolled member for the provision of all services covered by the contract. Such Responders will be at full risk for provision of the covered services. Responders will be expected to have access to sufficient reserves and/or reinsurance to bear the risk of unexpected medical claims which may occur. The State and its contracted actuaries will develop actuarially sound capitation rates which will be paid to the Responder. This is a requirement of the Centers for Medicare & Medicaid (CMS) under 42 C.F.R. § 438.4.

6. Medical Assistance Participation Requirements in Minnesota

Pursuant to Minnesota Statutes, section 256B.0644, health maintenance organizations (HMOs) and vendors of medical care as defined in Minn. Stat. § 256B.02, subd. 7 must participate as providers or contractors in the Medical Assistance programs as a condition of participating in State and local government employee health insurance programs, the workers' compensation system, and insurance plans provided through the Minnesota Comprehensive Health Association (MCHA).

In addition, HMOs, Community Integrated Service Networks (CISNs), county-based purchasing (CBP) entities, and other qualified provider types must participate in the Minnesota Health Care Programs, including SNBC, as a condition of licensure/certification by the Minnesota Department of Health pursuant to Minnesota Statutes, sections 62D.04, subdivision 5 and 62N.25, subdivision 2.

In accordance with Minnesota Statutes, section 62D.04, subdivision 5, HMOs shall submit a proposal for this RFP for all counties in which they are licensed to serve the entire county.

SNBC operates under the authority of Minnesota Statutes, section 256B.69, subdivision 28, which provide that the Commissioner of Human Services may contract with demonstrations to provide medical assistance basic health care services to persons with disabilities.

7. Qualified Responders to this RFP

A Responder is required to submit a proposal in good faith that meets the requirements of this RFP provided that the requirements can be reasonably met by the Responder to serve individuals eligible for the programs in a geographic region of the State. To be eligible to respond to this RFP, Responders must meet all of the following criteria and fulfill all of the requirements included in this RFP.

(a) Managed Care Organization Definition

To be considered a qualified Managed Care Organization (MCO) for purposes of responding to this RFP, a successful Responder must meet the definition of an MCO. Under the federal rule governing managed care, MCO means an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

- i. A Federally Qualified HMO that meets the advance directives requirements of 42 C.F.R. §§ 489.100-104; or
- ii. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid enrollees covered under the fee-for-service program within the area served by the entity, and b) meets the solvency standards of 42 C.F.R. § 438.116.

In determining whether an entity meets the definition of a qualified MCO, the Commissioner has discretion to explore various provider options that will be most advantageous to the population eligible for enrollment in the managed care programs. Providing the above requirements are met, the Commissioner may contract with any organization that meets the definition of a demonstration provider or participating entity under Minnesota Statutes, sections 256B.69 subdivision 2, and 256L.01, subdivision 7 respectively.

(b) Health Maintenance Organization

Health maintenance organization (HMO) means a foreign or domestic corporation or a local governmental unit as defined in Minnesota Statutes, section 62D.02, subdivision 11, controlled and operated as provided in Minn. Stat. §§ 62D.01-30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

(c) Dual Special Needs Plan

Applicants for Medicare Advantage dual-eligible Special Needs Plans (D-SNPs) (initial, existing, and existing/expanding) must have a signed State Medicaid Agency contract by the deadline specified by the Centers for Medicare and Medicaid Services (CMS). A current evergreen, multi-year, or future contract must be uploaded to CMS each application cycle or year. Responders for Integrated SNBC must promptly submit a Notice of Intent to Apply (NOIA) to CMS and actively seek a Dual Special Needs Plan contract with CMS limited to the SNBC population under a unique H number. As noted in the CMS HPMS memo regarding Notice of Intent to Apply issued

October 15, 2021, “[w]here state Medicaid agencies request (or plan to request) that D-SNPs have separate contract numbers, organizations may submit a NOIA while we work with the state.”

Note: Responders who do not currently have a contract for SNBC are encouraged to contact Kristi Burt at SNP_RFPs@state.mn.us prior to submitting a NOIA to CMS to begin working through the requirements to bring up a new Medicare Advantage dual-eligible Special Needs Plan.

8. Information about the SNBC Population and Minnesota Counties

People between the ages of 18 and 64 with a disability may enroll in SNBC. “Disability” is defined in the as either being certified as having a disability through the Social Security Administration (SSA) or the State Medical Review Team (SMRT), or a person with Developmental Disability for the purposes of the developmental disability waiver, as determined by the Local Agency.

Enrollment in SNBC is voluntary, but automated. Eligible people who do not wish to remain enrolled in SNBC must opt out of the program. People enrolled in the Medicaid-only portion of SNBC may disenroll at any time, effective the end of the month. In order to be eligible for Integrated SNBC, a person must also be eligible for Medicare Parts A and B. People enrolled in Integrated SNBC may disenroll at any time, effective the end of the month, subject to the limitations of the Medicare Special Enrollment Period regulations.

SNBC members are medically complex; most have five or more chronic conditions with 70% of enrollees experiencing some type of behavioral health diagnosis. They may also experience social barriers that affect their ability to maintain health, such as unstable housing and supports, a lack of education, poor reading skills and other social factors. The majority of SNBC members may be well cared for by a standard provider with a few considerations typically: a longer appointment time, accommodations for specialized equipment or a quiet environment while waiting to be seen by the provider.

Below is a list of additional resources Responders may find helpful in understanding the Minnesota Health Care Programs (MHCP) and the population covered under these programs. This section also includes information on county demographics and specific county information for the counties included in this RFP.

County Demographics

County Specific Information



2022 Metro
Counties Combined

Find a Local Health Department or Community Health Board

<https://www.health.state.mn.us/communities/practice/connect/findlph.html>

SNBC Managed Care Enrollment Guide

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5567-ENG>

Managed Care Enrollment Numbers

http://www.dhs.state.mn.us/main/dhs16_141529

Medicaid Matters – The Impact of Minnesota’s Medicaid Program

<https://mn.gov/dhs/medicaid-matters/>

Minnesota Health Care Programs Brochure

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3182-ENG>

Special Needs BasicCare program brochure

<http://edocs.dhs.state.mn.us/lfserver/Public/DHS-6301-ENG>

Minnesota Health Care Programs Fact Sheet

<https://edocs.dhs.state.mn.us/lfserver/public/DHS-4932-ENG>

Medically Underserved Regional Listing

<http://muafind.hrsa.gov>

Community Health Clinics Listing

<https://findahealthcenter.hrsa.gov/>

Rates for Specific Programs – Please submit a request to: SNP_RFPs@state.mn.us

2. SCOPE OF WORK

2.1 Overview

This RFP provides background information and describes the services desired by the State. It describes the requirements for this procurement and specifies the contractual conditions required by the State. Although this RFP establishes the basis for Responder Proposals, the detailed obligations and additional measures of performance will be defined in the final negotiated contract.

The Responder must provide access to cost-effective, quality health care to eligible individuals covered under the Special Needs BasicCare and Integrated Special Needs BasicCare contracts. The SNBC and Integrated SNBC model contract includes comprehensive, preventive, diagnostic, therapeutic and rehabilitative health care services as specified in Article 6 of the contract. The model contract includes requirements for enrollment, MCO and enrollee communications, marketing and enrollee education, reporting requirements, access standards, transition services, service authorization, quality assessment and performance improvement, denials, terminations and reductions of service (DTRs), grievances, appeals, and state fair hearings, and other required provisions including compliance with various state and federal laws and regulations. Responder must comply with the program contract requirements specified in the model contract.

2.2 Tasks and Deliverables

The SNBC and Integrated contains all of the substantive tasks and deliverables that Responders must perform under the contract resulting from this RFP. Responders should carefully review the SNBC and Integrated SNBC model contract in the Appendix in this document. The State reserves the right to change tasks and deliverables in the contract during the negotiation period listed in the table “**Summary of Important Dates.**”

3. PROPOSAL REQUIREMENTS

Proposals must conform to all instructions, conditions, and requirements included in this RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal is at the Responder’s risk and may, at the discretion of the State, result in disqualification of the Proposal for nonresponsiveness. Acceptable Proposals must offer all services identified in Section 2, “Scope of Work,” agree to the contract conditions specified throughout the RFP, and include all of the items referenced in the Required Statements and Applicable Forms sections. Responder must also agree to the terms and conditions in the attached model contract unless specifically making an exception pursuant to the Exceptions to Terms and Conditions Form (DHS-7019) document found in Section 3.3, “Required Statements and Forms.”

3.1 Proposal Contents

Responses to this RFP must consist of all of the following components (see following sections for more detail on each component). Each of these components must be separate from the others. All proposals submitted under this RFP must address, in sufficient detail, how the Responder will fulfill the expected outcomes outlined in this RFP. Simply repeating the outcomes and asserting that they will be performed is not an acceptable response.

Proposal Components	RFP Section
1. Table of Contents	3.2(1)
2. Service Delivery Plan	3.2(2)
3. Professional Responsibility and Data Privacy	3.2(3)
4. Provider Network Adequacy Review	3.2(4)
5. Performance and Service Deliverables	3.2 (5)
6. Required Statements and Forms	3.2 (6)

3.2 Detail of Proposal Components

The following will be considered minimum requirements of the Proposal. The emphasis should be on completeness and clarity of content.

- 1. Table of Contents**
- 2. SNBC Service Delivery Plan:** The service delivery plan should describe the Responder’s organizational structure for care coordination model and delivery of health care services in the

SNBC program and, if applicable, Integrated SNBC. The service delivery plan should include, but is not limited to, the following components:

- A. Executive Summary:** The executive summary should demonstrate the Responder's understanding of the services requested in this RFP and any problems anticipated in accomplishing the work. It should include the Responder's overall design for achieving the deliverables, solutions to the problems presented, and knowledge of the requested services. Responders who have not previously offered SNBC or Integrated SNBC/SNBC should outline Responder's plan for implementation of SNBC or Integrated SNBC/SNBC
- B. Description of the Applicant Organization:** Provide a summary of the programs and activities of the organization, the number of people served, and the geographic areas served. Include information that demonstrates the Responder's capability to effectively deliver the services outlined in the RFP and serve the population covered by the RFP as well as strengths considered to be an asset to your programs. Include an organizational statement that includes its mission, philosophy, goals and objectives, quality of care and service program and overall structure of the organization. Specifically, the proposal should demonstrate the responder's plan for implementation of SNBC consistent with the "[SNBC Guiding Principles to Design, Implement, Evaluate, and Improve Services For Persons With Disabilities.](#)"
- C. Administrative Services:** Provide a description of staffing resources for administrative services and clinical services. Administrative services support but do not directly provide services to enrollees. These are services such as; human resource functions, daily plan operations, contract management, data and information management, continuous improvement, business and strategic plans, annual budget oversight, legal department, risk management, facilities management, etc. List and describe who has responsibility for and your organization's approach to oversight and coordination of administrative services.
- D. Appeals and Grievances:** Provide a description of how the organization ensures all components of its grievance system adhere to contract, State, and federal requirements regarding the handling of enrollee appeals and grievances for SNBC and Integrated SNBC. Include a summary of any monitoring protocols your organization has in place that evaluate your organization's policies and procedures related to appeals and grievances.

Care Coordination Model: At a minimum care coordination is a person-centered activity designed to assess and meet the needs of members, while helping them navigate through the health care system in order for the member to achieve optimal health. Advocates, providers and members in SNBC want to understand how care coordination operates within the Responders SNBC plan.

The organization must coordinate all covered services for its enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, the provision of culturally appropriate care, and fiscal and professional accountability. Describe how the Responder organization coordinates all covered services for its enrollees including dental, pharmacy benefits, physical health, behavioral health, mental health, substance use disorder (SUD) and long term care services and supports services. Include how the Responder care coordination approach intersects with its population health

management program and health equity goals. Responders should describe their care coordination model for Integrated SNBC and SNBC, as applicable. Responders may attach a CMS approved D-SNP Model of Care that describes their care coordination model.

If submitting a D-SNP Model of Care, Responders should clearly indicate where in the Model of Care the information requested below is found. Responders should indicate which components apply to Medicaid-only SNBC and describe any differences that exist between Responders Integrated SNBC and SNBC care coordination models. Outline the differences in the care coordination models between integrated and non-integrated programs. This includes any tiered levels of intensity of care coordination if included in the Responder's model.

If not submitting a D-SNP Model of Care, Responders should respond with the following information:

Please describe your care coordination model for SNBC. Provide complete and detailed responses. Include in the description:

1. Entities contracted to perform care coordination. Include in the response if internal health plan staff are involved in the care coordination model and describe the Responder's efforts to hire members of underrepresented populations.
2. Staff qualifications.
3. Expected ratio of staff to members.
4. The duties, functions, responsibilities and focus of staff at each level of intensity of the care coordination component.
5. Describe how your care coordination model tasks are accomplished, i.e. face-to-face, telephonic, mail, electronic, etc.
6. If an individual care coordinator is assigned immediately on enrollment to a member describe the following:
 - a. The triage criteria the Responder utilizes to assign members to various care coordination delegates;
 - b. When and how a member's preference is taken into consideration in the assignment process;
 - c. How, when and what information is given to members regarding the Responder's care coordination model.
7. The process for how a member can request a change of care coordinator. If an individual care coordinator is not assigned immediately on enrollment to a member describe the following:
 - a. Describe the triage criteria Responder utilizes to assign members access to various care management levels.
 - b. Describe when and how a member's preference is taken into consideration in the assignment process.
 - c. Describe how referrals are made for care coordination after initial enrollment
 - d. Describe the criteria used to accept a member for care coordination services
 - e. Describe when and how the Responder's member services offers a referral for care coordination.

- f. Describe the instructions for health care providers on how and when to request care coordination for SNBC members.
 - g. Describe how, when and what information is given to members regarding the care coordination.
 - h. Do all members receiving care navigation get a written, member specific care plan?
 - 8. Describe how the Responder's care coordination model will increase member engagement and how members gain knowledge, skills, tools and confidence to become active participants in their care.
 - 9. Describe how the Responder's model supports coordination of both Medicare and Medicaid services.
 - 10. Describe how and when the Responder's care coordination model follows up with a member when unmet needs are identified through the HRA process, Responder's member services, data analysis, family concerns or provider communication to the Responder.
 - 11. Include protocols for access to individual intermittent telephonic care management.
 - 12. Include protocols for access to ongoing intensive care management including face-to-face assistance.
 - 13. Include written protocols for accessing and declining case management services.
 - 14. If the Responder's care coordination model incorporates a care coordination team approach with various levels of intensity of care coordination such as complex care coordination, care coordination, care management, care navigation or care guide, the Responder must complete and submit detailed responses for each level of intensity of care coordination provided to MSHO members.
 - 15. If the Responder's care coordination model changes depending on the member's living arrangement or changes depending on rural vs. metro service area, the Responder must complete and submit detailed responses
- E. Claims and Encounter Data:** The organization should provide a description of how claims are paid and encounter data are submitted. Include whether any processes have been subcontracted out and if so, how the subcontractor is kept up to date on changing information and requirements. Describe and provide any standards the organization has put in place to ensure timely payment of all claims. Indicate whether the organization completes any post payment claims review. Identify how often the organization audits its claims payment and encounter data submission processes. Detail how the organization ensures the accuracy and appropriateness of claims payments as well as how the organization coordinates any third party liability (TPL) benefits.
- F. Compliance/Internal Auditing/Fraud Prevention/Restricted Recipient Program (RRP):** Provide a description of the organization's established program integrity functions and activities to reduce the incidence of fraud, waste, and abuse. Describe how your organization has coordinated your RRP with program integrity functions. Provide a summary of your subcontractor delegation audit reports for the past year including information regarding any corrective action plans (CAP) and how any issues in the CAP were resolved.
- G. Enrollment/Customer Service/Marketing/Communication:**

Enrollment: Describe the Responder organization’s process for loading enrollment files for SNBC and Integrated SNBC (if applicable). Include any standards established by your organization for how quickly enrollment files are passed through to any subcontractors, e.g. pharmacy benefit managers (PBM), dental, etc. Explain any delays experienced in forwarding these files during the past year.

Customer Service: Provide a summary of the Responder organization’s enrollee call center assistance for SNBC and Integrated SNBC. Include where the call centers are located, how enrollees learn where to call, call center hours of operation differentiating between seasonal hours, accommodations other than English, lines of business, and how many different call centers are used for which services, e.g. transportation, medical, etc. Include your customer call center staffing ratio for membership size and whether that is adjusted “seasonally.” Describe any established call center standards such as acceptable call center wait times and customer service quality.

Marketing/Communications: Describe the Responder organization’s approach to communicating with enrollees, counties, tribes, community or social service organizations, and providers. Include whether your organization offers an enrollee portal, uses subcontractors for any marketing or enrollee communication responsibilities, and if so, which parts. Explain what area of your organization maintains oversight of these functions and how each of these functions work within your organization.

- H. Financial Management:** Describe how the Responder organization determines and sets your Medicaid payment rates for **providers**. Provide how your organization determines those rates to be the most appropriate payment rates.
- I. Information Technology:** Describe the Responder organization’s approach to information technology. List the information systems the organization utilizes and what each system is used for. Include whether the organization’s main administrative system interacts with your clinic care systems and in what ways, as well the frequency of any exchange. Include a description of the organization’s information systems used for data collection, statistics, quality improvement activities and reporting, including how the organization uses the data in its delivery of health care services.
- J. Medical Director(s):** Describe the role and responsibilities for all medical directors in your organization. Provide your medical directors’ vision for the MCO and how your organization plans to achieve that vision.
- K. Population Health Management:** Provide the organization’s population health management (PHM) strategy, program structure, population assessment, health activities, health experience, and foundation of the organization’s role in local initiatives, quality of care, and delivery. Identify what area of the organization is responsible for implementing these strategies.
- L. Provider Network Administration:** Describe how your organization captures provider information required to be submitted on the monthly provider network file to DHS. Include whether the organization tracks provider cultural competency training, facility and equipment accommodations that are available for enrollees with disabilities, and information regarding

which providers are accepting new patients. Describe any provider standards that have been established in these areas and how any gaps are identified and addressed. Include any documentation completed over the past calendar year that evaluated whether those standards were met and how any gaps were addressed.

1. How does the Responder assess the provider network to assure it meets the needs of its members?
2. How does Responder monitor member experience and utilization to ensure that its provider network is sufficient, including specialty and behavioral health services? Please include Responder's approach to ensuring access to culturally appropriate care and access for underserved populations within the senior population?
3. Please provide an overview of monitoring activities and a specific example of action taken in response to concerns Responder identified about network adequacy for people with disabilities. Include a description of the role care coordination plays in providing information to Responder regarding gaps in the provider network, accessibility of providers to meet the needs of member; availability and willingness of providers to work with members, and solving barriers for members and providers.

M. Quality Management:

Provide the following information in reference to your organization's quality management program (if applicable):

- Accreditation Status
- Mechanisms to address special health care needs if your organization has an alternative mechanism to what is described in 7.1.5.1 of the model contract in Appendix A.
- Paragraph summary of Performance Improvement Projects (PIPs)
- Description of your organization's participation in any enrollee satisfaction surveys as described in 7.4 of the model contract in Appendix A.
- Description of your organization's efforts to assess enrollee satisfaction and address the results of those efforts.

N. Utilization Management: Provide a description of the organization's utilization management (UM) program. Include a description of the organization's service authorization and referral requirements. Explain which services require prior authorization, requests for second opinions, out-of-network referrals, and procedures for continuity of care. Also explain how your organization ensures parity between physical and behavioral health services.

O. Stakeholder Meetings: The contract and the managed care regulations require that Responder hold stakeholder meetings to solicit input on implementation of the program. See 42 C.F.R. §§ 438.110 and 438.70. In addition, Minnesota Statutes, section 256B.69, subdivision 28(e) states: Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area. If the Responder does not currently have a SNBC/Integrated SNBC contract with the State, the Responder should select a current market or product to use in the responses

to questions regarding current policies, procedures, or experiences including how they address the varied needs of the population throughout a diverse service area. The Responder should also name the market and product selected.

1. Provide a description of the organization's stakeholder engagement activities for Integrated SNBC/SNBC and describe how the Responder conducts their contractually required Integrated SNBC/SNBC stakeholder meetings. Include in the response:
2. Who is informed of the stakeholder meetings? How are they informed and how much lead-time are they given? How are members informed that they can present or comment at stakeholder meetings?
3. How is the agenda determined for the stakeholder meetings? How would members know how to suggest agenda items? Describe how the Responder's staff will follow up to ensure that the topic is discussed at the next stakeholder meeting. If the Responder does not add the topic to a future agenda for a stakeholder meeting, what is communicated back to the member and to the Responder's leadership?
4. How will the Responder engage members with language barriers and special needs?
5. How are members in greater Minnesota included in these meetings?
6. How are customer service representatives/member help desk staff and care coordination model staff educated about the meeting dates, agenda, etc. so they can respond to member questions?
7. Describe how the Responder solicits and/or receives member feedback regarding satisfaction, communications, service delivery, provider networks, and health plan operations outside of stakeholder meetings.
 - a. Describe how the feedback is used in the organization's operations.
 - b. Describe efforts to use this feedback to assess underserved members experiences in order to improve health outcomes for the SNBC population.
 - c. Describe how members become aware of changes implemented after hearing about members concerns or why changes were not made after hearing their concerns?

3. Professional Responsibility and Data Privacy:

- i. **Professional Responsibility:** It is crucial the State locate reliable grantees to serve our clients. Therefore, Responders must be professionally responsible and include satisfactory information regarding their professional responsibility in their Proposals. Per Minnesota Office of Grant Management (OGM) Policies [08-02](#)¹ and [08-13](#),² Responder's past performance as a grantee of State will be considered when evaluating a grant application. Professional responsibility information includes information concerning any complaints filed with or by professional, State and/or federal licensing/regulatory organizations within the past six years against your organization or employees relating to the provision of services. If such complaints exist, please include the date of the complaint(s), the nature of the

¹ https://mn.gov/admin/assets/08-02%20Grants%20Policy%20Revision%20September%202017%20final_tcm36-312046.pdf

² https://mn.gov/admin/assets/grants_policy_08-13_tcm36-207120.pdf

complaint(s), and the resolution/status of the complaint(s), including any disciplinary actions taken.

All Proposals must also include information about pending and/or resolved litigation within the past two years that relates to the provision of services by your organization and/or its employees. Please include the date of the lawsuit, nature of the lawsuit, the dollar amount being requested as damages, and if resolved, nature of the resolution (e.g., settled, dismissed, withdrawn by plaintiff, verdict for plaintiff with amount of damages awarded, verdict for Responder, etc.). If no litigation is pending, please make a note of this in the narrative for this section.

Responder may submit information which demonstrates recognition of their professional responsibility, including references and/or letters of recommendation. This may also include awards, certifications, and/or professional memberships.

Finally, if applicable, note whether as a Medicare Advantage Plan Sponsor CMS has taken final enforcement or contract action towards the Responder for any of the following for CY 2020, CY 2021 and/or CY 2022:

1. Substantially failing to comply with program and/or contract requirements,
2. Carrying out its contract with CMS in a manner that is inconsistent with the efficient and effective administration of the Medicare Part C or Part D program requirements, or
3. No longer substantially meeting the applicable conditions of the Medicare Part C or D program.

If Responder response is “Yes”, describe the enforcement action taken by CMS, including civil money penalties, intermediate sanctions (i.e. suspension of marketing, enrollment, payment) and/or termination. Include the initial and termination dates of each sanction.

The State will determine if the severity of the underlying infraction(s) warrants a rejection of the proposal or a reduction of up to five (5) points per sanction from the overall score.

The information collected from these inquiries will be used in the State’s determination of the award of the contract. It may be shared with other persons within the Minnesota Department of Human Services and Department of Health who may be involved in the decision-making process and/or with other persons as authorized by law. You are not required to provide any of the above information. However, if you choose not to provide the requested information, your organization’s Proposal may be found nonresponsive and given no further consideration. The State reserves the right to request any additional information to assure itself of a Responder's professional status.

- ii. **Data Privacy:** The Responder should include a response to all of the components listed in the attachment entitled [Data Privacy](#). As stated in the Data Privacy attachment, Responders will need to complete three parts: (1) A narrative description of their privacy program, (2) The Minnesota Information Technology Services (MN.IT) Vendor Security & Compliance Questionnaire, and (3) Listing of Sensitive Data Breaches.

4. Provider Network Adequacy Review

Before the State can sign a contract with any Responder, the Responder must demonstrate that its network will provide appropriate levels of access.

All Responders must provide the following:

- i. [Network Adequacy Attestation Document](#)

- ii. **Provider Network Listing – not required as part of RFP submission on February 18, 2022**

Responder is not required to submit a provider network listing with the RFP submission on February 18, 2022. Responder may be asked for a provider network listing during the Readiness Review period. If required, the provider network listing must be submitted for your proposed service area electronically on a USB drive using the [Provider Network Listing template](#) (Excel file). It is imperative that the Responder follow the specifications for the submission of the network. The provider network listing should include up-to-date comprehensive provider information.

Report Specifications:

A Provider Network Listing template is included below with a Data Dictionary that includes the instructions for completing the provider listing.

The Provider Network Listing must include Essential Community Providers (ECPs) available within the designated service area as required by Minnesota Statutes, section 62Q.19.

Responders may submit the provider network listing as a .Zip file to minimize the file size.

- iii. **Geographic Access Maps**

Responders must plot the provider location on each map. Include the following information on each map:

- Provider Type indicated in the title of the map (e.g., General Hospital facilities, Primary Care providers).
- Product Name indicated in the title of the map (e.g. Medical Assistance or MinnesotaCare).
- The name of each county in your service area must be identified on each map.
- Proposed service areas must be clearly highlighted on each geographic access map.
- Maps must be clear and easy to read such that all provider locations, county names, and access markers are visible. The background color must be neutral (white, pale yellow, or pale tan).

Consult the SNBC Geographic Access Map Specifications for instructions on what geographic access maps are required.

[SNBC Geographic Access Map Specifications](#)

iv. Gap Analysis Summary

Provide a comparative analysis of the network by identifying any gaps shown on the maps (by county) for any of the following required provider types.

Analysis documentation should describe where access is not sufficient, including when geographic mileage access criteria are not met, the reason access is not sufficient and how the Responder will ensure access to services covered under the current model contract. Responders may be asked to submit a “Request for Waiver” documenting the reasons that all access criteria cannot be met.

v. Managed Long Term Services and Supports Access

The long term services and supports provided in the Integrated SNBC/SNBC contract include:

- 1) Home Care Skilled Nurse Visit, described at Section 6.1.24 of the Model Contract
- 2) Home Care Home Health Aide, described at Section 6.1.24 of the Model Contract
- 3) Home Care Therapies, described at Section 6.1.24 of the Model Contract
- 4) Nursing Facility, described at Section 2.136 of the Model Contract

For each of the above, answer the following questions

- 1) May enrollees use any enrolled Medicaid provider for this service?
- 2) Must enrollees use a network provider for this service and, if so, is the Integrated SNBC/SNBC network for the service smaller than the number of DHS-enrolled provider in the MCO’s service area?

- 3) If the answer to question 2 is yes and an enrollee wants to use an out of network provider, describe the process and/or criteria to determine when use of an out of network provider will be allowed. Describe how an out of network provider will receive appropriate instructions on how to bill and be paid. Include specific references to sections of the Service Delivery Plan as needed.
- 4) If the answer to question 2 is yes, describe how Responder meets Generally Accepted Community Standards, i.e. how the MCO assures that access to the service is equal to or greater than that currently existing in the Medical Assistance fee-for-service system in the MCO service area. If applicable, describe how this is accomplished in metro and non-metro areas. Include specific references to the Service Delivery Plan, Section E, Care Coordination Model, as needed.
- 5) If the answer to number 2 is yes, describe how Responder ensures that Enrollees have a choice of providers, comparable access, high quality services, expertise for special needs, and the option for an Enrollee in need of services to reside in or near their home community. Include specific references to the Service Delivery Plan, Section E, Care Coordination Model, as needed.
- 6) Please describe how Responder uses care coordination to assist in obtaining access to appropriate providers to meet identified long term service and support needs. Include specific references to the Service Delivery Plan, Section E, Care Coordination Model, as needed.

5. Performance and Service Deliverables

The following sections include questions that will receive a numerical score. The responses to these questions should demonstrate the Responder's understanding of the SNBC and Integrated SNBC population, challenges and opportunities related to health care delivery, and unique approaches to providing services to the population covered under the SNBC and Integrated SNBC contract throughout Responder's proposed service area. Responses should demonstrate the potential for innovation and increased value inherent in the managed care structure and not available in the fee-for-service (FFS) delivery system. These questions reflect both State and County priorities and should address, where applicable, racial disparities, county and community collaboration, and person-centered design even if the question does not expressly state those themes. All responses must address any differences between Responders' administration of the Integrated SNBC and SNBC programs and when serving various portions of the service area.

This RFP covers the entirety of the State and therefore each response to the questions in this section should indicate how the Responder addresses the various needs of SNBC population throughout their service area. If the Responder does not currently have a SNBC/Integrated SNBC contract with the State, the Responder should select a current market or product to use in the responses to questions regarding current policies, procedures, or experiences including how they address the varied needs of the population throughout a diverse service area. The Responder should also name the market and product selected.

Responses to Sections 1-9 of the Performance and Service Deliverables must be no more than ninety (90) total pages in length. Responder may refer the reader back to the Service Delivery Plan, Section E, Care Coordination Model, as needed to prevent repetition.

Section 1: Continuity of Care/Plan Transitions

10 points

Scenario:

Mr. Q is a Medicaid eligible member who will be enrolled in the Responder's SNBC plan on the first of the month. He has a diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD), a condition that can take time to treat and, for many people, is a lifelong condition.

After many years of trying various medications and attempts at psychotherapy, his medical team has developed a plan of care that successfully manages his symptoms. He has built a trusted relationship with a psychiatrist who has prescribed a medication for CPTSD that is not on the health plan's formulary and requires a special authorization. His work with his mental health therapist has greatly improved his quality of life to the point where he works occasionally and is talking about joining a support group. His mental health therapist is not a network provider in your plan. Next month, he will be eligible for Medicare.

Describe the steps the Responder will take to ensure Mr. Q continues to receive his medications and needed mental health services.

Include in the response:

1. Explain the role of the care coordinator in assuring access to needed services and medications within a reasonable period of time.
2. How will care coordination staff be alerted to prioritize cases like Mr. Q?
3. What information or reports are available to care coordination staff indicating Mr. Q's needs?
4. How will the non-contracted provider be engaged? What is the process for adding the non-contracted provider to the network?
5. How the above may differ depending on Integrated SNBC vs SNBC, metro vs rural, and the care coordination model in use in a particular part of the service area.

Section 2: Continuity of Care/ Transition to Medicare Coverage 7 Points

Scenario:

The scenario above is similar to Scenario 1, but this time Mr. Q has been with your SNBC program for over a year. He will become newly eligible for Medicare at the first of the following month. His mental health therapist is not a Medicare provider.

Describe the steps the Responder will take to ensure Mr. Q continues to receive his medications and needed mental health services.

Include in the response:

1. Explain the role of the care coordinator in assuring access to needed services and medications within a reasonable period of time.
2. How will care coordination staff be alerted to prioritize cases like Mr. Q?
3. What information or reports are available to care coordination staff indicating Mr. Q's needs?
4. How will the non-Medicare provider be engaged? What is the process for ensuring continuity of mental health care?
5. How the above may differ depending on Integrated SNBC vs SNBC, metro vs rural, the care coordination model in use in a particular part of the service area.

Section 3: Care Coordination Training and Support 10 Points

Scenario:

The responder is bringing up a new delegate to work as SNBC care coordinators. Members have identified that for them the health care system is growing more complicated and the need for the navigational component that care coordinators provide is growing. Care coordinators have requested to be trained to know how to keep members out of crisis and receive training on the best practices for various situations including inpatient admissions, mental health resources or ensuring better quality of life for members in the community.

In this section, describe the Responder's training and other supports given to all staff involved in the SNBC care coordination model. Include in this response:

1. How known gaps in the Responder's health care services are communicated to care coordinators. Provide a specific example of a gap in the Responder's health care system that has been communicated to care coordinators and what alternatives the care coordinator are told to offer the member.
2. The training care coordinators receive on:
 - The SNBC benefits package,
 - The appeals and grievance processes,
 - Transportation scheduling,
 - Benefit exceptions,
 - Access to Responder's medical and behavioral health specialists for consultation, and
 - Services that the members may access through the county, fee for service, and other local resources that are available to the member.
4. How the Responder will use of the DHS monthly SNBC [New Enrollee Utilization reports](#) sent to the health plans. Include what information is shared with the care coordinator, when the information is shared, how is it shared and with whom it is shared.
5. How the Responder utilizes its own data to support its care coordination model.
6. The training for care coordinators in cultural competency and person-centered care.
7. Trainings regarding populations experiencing disadvantages and any regional variation in those trainings.

Section 4: Member engagement and communication: stakeholder input

7 Points

Scenario:

Mr. N is a non-English speaking member of SNBC and has had some upsetting encounters when seeking health care. He shared his concerns about how members are treated with his care coordinator and MCO member services staff. They told him that he could file a grievance and that if he wanted to switch clinics, they could mail him a list of other clinics. Care coordinator staff stated that if Mr. N does not want to change clinics, there was nothing more they could do.

Mr. N wants to share his concerns with MCO staff in order to improve members' experiences. He has attended stakeholder meetings with health plan staff during his three-year enrollment with SNBC but is frustrated that the meetings were mainly about members' transportation concerns. He feels there are other important topics that need addressing, including:

- Low-quality eyeglass frame options is a persistent problem. Not only is the quality low but an optician dumped a box of frame samples in front of Mr. N to choose from while other people were shown various examples of eyeglass frames from a display.
 - Front desk staff at some clinics and dental offices have told SNBC members they have to wait longer for appointments than people with private insurance.
- 1) Describe how the Responder would respond to Mr. N's concerns.
 - 2) Describe a specific issue raised by your stakeholders. Include a description of what the issue was, how it was brought to the Responder's attention, how the Responder engaged members, changes the Responder made based on stakeholder feedback, how the impact of that change was measured, and how members were made aware of the resulting change. Include a description of how the County and care coordination staff were made aware of the issue, consulted on the intervention, and engaged in the process.

Section 5: Substance Use Disorder (SUD)

10 Points

At the quarterly Responder and County Partnership meeting, county Public Health staff share their concerns with the Responder, regarding what appears to be an increase in substance use, relapses, and overdoses among members of their community. Staff think that for some member anxiety, depression and isolation related to the pandemic and pandemic response may be contributing to an increase in use of alcohol and other substances. Public Health staff are requesting to work with the Responder on their concerns regarding substance use by enrollees in the County.

- 1) Describe a specific initiative (before or during the COVID-19 outbreak) the Responder has implemented to address the increase in substance use, relapses, and overdoses among people with disabilities. Describe the selection of the initiative, the planning process, implementation and evaluation. Describe how the Responder's initiative takes into consideration clinical, demographic and socioeconomic factors. Include information about accommodating members with mild vs moderate to severe SUD, abstinence vs. active substance use, consumption of multiple substances, and members with comorbid psychiatric disorders. Include a description of what data Responder shares with county public health staff and how Responder and the county public health staff use the data to work toward improving population health. Include how Responder engages providers and members in conversation about SUD health care services and treatment in a culturally appropriate manner.
- 2) Describe what your organization has learned from the COVID public health emergency with respect to SUD care delivery for members with disabilities. Include specifics on data being monitored to identify trends the Responder has identified. Describe specific strategies and innovations for prevention and treatment for SUD your organization implemented with this population. What strategies will continue beyond the pandemic?
- 3) Describe how the Responder is supporting health care professionals and care coordinators to better understand the risks, challenges and treatment options for members during and after the COVID-19 outbreak. Include a description of how the Responder reinforced the need for SUD

treatment to continue despite the challenges presented by the pandemic in order to avoid complications of SUD and COVID.

Section 6: Maintaining member eligibility

10 Points

Scenario:

Mr. T is a managed care member who has been continuously enrolled in an SNBC health plan for two years without a spenddown. He has diagnoses of paranoid personality disorder (PPD) and generalized anxiety disorder. The SNBC enrollment file included his Medical Assistance (MA) eligibility renewal date. The care coordinator noted in his support plan that he struggles with paper work.

Mr. T started a new job and will now have a spenddown. He told his financial worker he cannot afford to pay the spenddown and will not pay it since there is no premium for enrollment in SNBC. He then called his care coordinator to report that his financial worker does not understand that there is no premium for a person enrolled in SNBC so he will not pay the spenddown. He also told his care coordinator that he would not complete the paperwork for Medicare Part B insurance since he says, "he has SNBC insurance."

Mr. T also called his health plan's member help desk to tell them he received a letter from the State Medical Review Team (SMRT) at the Department of Human Services stating that his disability certification period will be ending in thirty days. He needs help understanding and completing the recertification paperwork if he requires ongoing disability-based MA healthcare eligibility.

Describe what Mr. T would experience from your health plan in terms of assistance with renewal and maintaining eligibility. Include in your response:

- 1) Briefly describe Mr. T's unique challenges and issues. Describe the training staff will need based on this scenario. What topics would be covered in the training?
- 2) Briefly describe the role and expectations of the Responder's care coordination model and member services staff in assisting the member to understand the various programs and complete the needed paperwork.
- 3) Briefly describe how the Responder will collaborate with county staff to assist this member.
- 4) Describe what differences exist with respect to the questions outlined above between integrated SNBC and SNBC, as well as metro and rural portions of the service area.
- 5) Describe how the Responder will make sure its care coordinators/navigators and member services staff communicate with each other about a member's concerns so that the member does not have to repeat their story to multiple people.
- 6) Please provide a high level description of how the Responder would address the issue of enrollment churn for all enrollees.

Section 7: Improving Outcomes and Eliminating Disparities

19 Points

SNBC health plans are expected to work hard to help people achieve optimal health regardless of:

- Race and/or Ethnicity
- Level of education
- Gender identity
- Sexual orientation
- Where they live
- Whether or not they have a disability

People residing in rural areas face difficulties accessing primary medical care especially when they are a member of a group or groups that experience disadvantages. Advocates and members of SNBC report access to medical care for all populations in rural areas is often delayed due to the difficulty of finding providers trained in treating complex needs, poor coordination of care between urban and rural health care providers and member's lack of education regarding their eligibility for health care service and how to access them.

- 1) Identify the various populations that receive coverage in your SNBC service area who experience barriers to health care. Describe those barriers.
- 2) Describe initiatives you will provide to help improve the experiences for communities that experience barriers and disparities in health care outcomes.
- 3) How does the Responder organization establish and maintain processes that are culturally responsive and that support the integration and coordination of an enrollee's primary care, behavioral health, and dental care? How do you identify the enrollees that will benefit from further coordination?
- 4) Describe steps the Responder organization has taken and/or will commit to taking to reduce implicit, explicit, and institutional bias experienced by people with disabilities. How are these actions monitored? How will these actions be sustained and/or adjusted in the future?
- 5) Describe how the Responder facilitates communication between urban and rural physicians, care managers, mental health providers and other medical services provided by the SNBC plan. Include in this response how the Responder connects groups that experience disadvantages to social and other services provided outside the SNBC benefit package.
- 6) How does your organization establish and maintain processes that are culturally responsive and that support the integration and coordination of an enrollee's primary care, behavioral health, and dental care? How do you identify the enrollees that will benefit from further coordination?
- 7) Describe how your organization solicits and/or receives feedback from county staff regarding service delivery, provider networks, and health plan operations for the SNBC and Integrated SNBC population.
 - a) Describe how that feedback is used in your organization's operations to improve outcomes for groups that experience disadvantages and support and support county health care activities.
 - b) Describe how county staff become aware of changes implemented after hearing their concerns or why changes were not made after hearing their concern.
 - c) Give an example of a change in their health care system the responder made based on county feedback. Describe how Responder measured the impact of that change.

Section 8: Transportation Access

10 Points

Scenario:

Mr. M is enrolled in an SNBC health plan and usually uses a wheelchair when he goes outside the home as he has unstable joints that can give out without warning, muscles with an unpredictable tendency to spasm and nerves that will occasionally make his whole leg numb. Trying to walk with these conditions can be exhausting, painful and unsafe. On rare occasions, he is able to use a walker, depending on his energy and pain level. In addition to his mobility concerns, Mr. M has diagnoses of generalized anxiety disorder and brittle diabetes.

On Friday afternoon, he calls his primary care physician office. For the past 36 hours he has experienced severe swings in his blood sugar with occasional dizziness. He is told he needs to come in to see his physician this afternoon and to expect lab work.

Mr. M calls the transportation company and is told that they are unable to accommodate same day rides. Mr. M is extremely stressed as he has had multiple hospitalization related to his brittle diabetes. He calls the health plans member services for help and they tell him transportation providers are typically available 8 am to 6 pm, Monday to Friday.

Mr. M also worries he will not get transportation as he has previously made grievances about drivers who told him “you really don’t need a wheelchair”, grabbed his mobility device without permission, did not help him to the second floor front desk for his appointment and some drivers talked on their hand held cell phone while driving carelessly through traffic.

Include in the response:

- 1) Describe the Responder’s transportation network and its operation. Include the Responder’s approach to transportation network maintenance and development for urban, suburban and rural portions of the service area.
- 2) Describe how the Responder will assist the member when a transportation provider does not provide the agreed upon return ride home. Include in this response how the Responder arranges for transportation home or overnight housing when it is after standard transportation hours.
- 3) Describe the follow up the Responder had with the transportation provider about Mr. M’s previous grievances. What did the Responder communicate back to Mr. M and his care coordinator regarding his transportation concerns?
- 4) What information is collected and analyzed in order to improve service and access? How does the Responder use data to identify barriers and improvements within the transportation system? Provide an example.
- 5) What information do they share with the member’s care coordinator regarding the member’s urgent need for transportation?
- 6) What transportation options for short notice, on-demand service are available for Mr. M?
- 7) Describe the education members receive on how to report transportation concerns. Attach any written documentation provided to members about transportation.

Section 9: Dental access

7 Points

Scenario:

Mr. N lives in a group home in a rural county and takes medication that makes it very important for him to get quarterly cleanings. Group home staff are seeking a dental appointment and they are aware that staff may need to be present to assist Mr. N due to extreme anxiety over medical procedures. They use the Provider and Pharmacy Directory provider by the Responder to call dental offices in the area where the directory indicates the dentist is taking new clients. They are told by many dental offices that they are, in fact, no longer taking new clients and that even if they did, they wouldn't feel comfortable seeing patients like Mr. N or seeking authorization to provide such frequent cleanings. Staff calls the Responder's Member Services for assistance.

- 1) What process does Responder have in place to find out which dental providers are currently taking new clients?
- 2) How does the Responder assure that providers listed in the Provider and Pharmacy Directory are taking new clients and are comfortable serving people with disabilities?
- 3) What is the role of the Responder and care coordinator regarding willingness of provider to work with a particular member, solving barriers for members and providers?
- 4) If the status of a provider changes, how is this change communicated to members who are currently seeking access to a provider and to care coordinators who may be assisting members?
- 5) How will the Responder assist in accessing dental services? What is the role of the care coordinator in assisting the member?

6. Required Statements and Forms

Complete the correlating forms found in [eDocs](#)³ by searching for the form numbers referenced below, or by pasting the form file path name found in the footnotes below to your browser, and submitting the completed forms in the "Required Statements and Forms" section of your Proposal. You must use the current forms found in eDocs. Failure to submit a Required Statement or to use the most current forms found in eDocs is at the Responder's risk and may, at the discretion of State, result in disqualification of the Proposal for nonresponsiveness.

a. Responder Information and Declarations and County List

1. ([Responder Information/Declarations Form DHS-7020-ENG](#))⁴: Complete the "Responder Information and Declarations" form available at the above link and submit it with the Proposal. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form. Responder may fail the Required Statements Review in the event that Responder does not affirmatively warrant to any of the warranties in the Responder Information and Declarations. Additionally, State reserves the right to fail a Responder in the event the Responder

³ <http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp>

⁴ <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-7020-ENG>

does not make a necessary disclosure in the Responder Information and Declarations or makes a disclosure which evidences a conflict of interest.

2. County List: Check the applicable boxes for the counties within this Responder's current licensed service areas, and the counties this Responder is proposing to serve in this proposal. Responder must submit the completed [Minnesota SNBC County List](#) Excel spreadsheet with their Proposal.

b. Disclosure of Ownership and Management Information

Federal law (42 C.F.R. § 455.104) requires Responders to disclose ownership and control interest. Responders must not have a director, officer, partner, agent, managing employee or other person with a 5% or more Ownership or Control Interest in their business entity, either directly or indirectly, if the person is excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act or have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program.

Responders must complete both the [Disclosure of Ownership Reporting Template](#) and the [Disclosure of Ownership Report Attestation](#) and submit with their Proposal

- c. Exceptions to Model Contract and RFP Terms ([Exceptions to Terms and Conditions Form DHS-7019-ENG](#))⁵:** The contents of this RFP and the Proposal(s) of the successful Responder(s) may become part of the final contract if a contract is awarded. A Responder who objects to any condition of this RFP or State's model contract terms and conditions (attached as Appendix A) must note the objection(s) on the "Exceptions to Model Contract and RFP Terms and Conditions" form available at the above link and submit it with its Proposal. Much of the language reflected in the model contract is required by statute. Only those exceptions indicated in your response to the RFP will be available for discussion or negotiation.

Responders are cautioned that claiming either of the following may result in its Proposal being considered nonresponsive and receiving no further consideration:

1. Exceptions to the terms of the standard State contract that give the Responder a material advantage over other Responders; or
2. Exceptions to all or substantially all boilerplate contract provisions.

Responders are cautioned that any exceptions to the terms of the model contract which give the Responder a material advantage over other Responders may result in the Responder's proposal being declared nonresponsive or result in the reduction of points from the overall score. **If there are exceptions noted, the State will determine if the exception(s) results in a rejection of the proposal or a reduction of up to five (5) points from the overall score.** Proposals that take blanket exception to all or substantially all boilerplate contract provisions will be considered nonresponsive proposals and rejected from further consideration for contract award.

⁵ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7019-ENG>

d. Disclosure of Funding Form ([Disclosure of Funding Form- DHS-7018-ENG](#))⁶:

In order to comply with federal law, Responder is required to fill out the “Disclosure of Funding” form available at the above link and submit it with its Proposal. The form requires Responders to provide their Data Universal Numbering System (DUNS) number, which is the nine-digit number established and assigned by Dun and Bradstreet, Inc. (D&B) to uniquely identify business entities. If a Responder does not already have a DUNS number, a number may be obtained from the D&B by telephone (currently 866-705-5711) or online (currently at <http://fedgov.dnb.com/webform>). Responders must have a DUNS number before their Proposal is submitted.

e. Human Rights Compliance:

i. Workforce Certificate Information. ([State of Minnesota Workforce Certificate Information- DHS-7016-ENG](#))⁷: *(Applies if a resulting contract will be in excess of \$100,000)*. Responder is required to complete the “Workforce Certificate Information” document available at the above link and submit it with its Proposal.

As required by Minnesota Rules part 5000.3600, subpart 9, “[i]t is hereby agreed between the parties that Minnesota Statutes, section 363A.36 and Minnesota Rules parts 5000.3400 - 5000.3600 are incorporated into any contract between these parties based upon this specification or any modification of it. A copy of Minn. Stat. § 363A.36 and Minnesota Rules parts 5000.3400 - 5000.3600 are available upon request from the contracting agency.”

. Equal Pay Certificate. ([Equal Pay Certificate Compliance – DHS -7075-ENG](#))⁸: *(Applies if a resulting contract will be in excess of \$500,000)*. Pursuant to Minnesota Statutes, section 363A.44, Responder must complete and submit the form available at the above link with its Proposal if the resulting contract with all amendments will be in excess of \$500,000 and Responder has had 40 or more full-time employees in Minnesota or its principal place of business in a single day during the prior 12 months. It is the Responder’s sole responsibility to provide the information requested and when necessary to obtain an Equal Pay Certificate from the Minnesota Department of Human Rights (MDHR) prior to contract execution. This section does not apply to a contract to provide goods and services to individuals under Minnesota Statutes, Chapters 43A, 62A, 62C, 62D, 62E, 256B, 256I, 256L, and 268A, with a business that has a license, certification, registration, provider agreement, or provider enrollment contract that is prerequisite to providing those goods and services.

Please contact MDHR with questions at: 651-539-1095 (metro), 1-800-657-3704 (toll free), 711 or 1-800-627-3529 (MN Relay) or email at compliance.MDHR@state.mn.us. Responder must apply for an equal pay certificate by paying a \$150 filing fee and submitting an equal pay compliance statement to the Minnesota Department of Human Rights (“MDHR”). MDHR’s Equal Pay Certificate instructions and Application Form can be obtained at this [link](#).⁹

⁶ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7018-ENG>

⁷ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7016-ENG>

⁸ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7075-ENG>

⁹ <https://mn.gov/mdhr/certificates/equalpay/>

It is Responder’s sole responsibility to submit this statement to MDHR and – if required – apply for an equal pay certification before the due date of this Proposal and obtain the certification prior to the execution of any resulting contract.

If a contract is awarded to a business that does not have an equal pay certificate as required by Minnesota Statutes, section 363A.44, or is not in compliance with the laws identified within Minn. Stat. § 363A.44, MDHR may void the contract on behalf of the State, and the contract may be abridged or terminated by the State upon notice that the MDHR has suspended or revoked the certificate of the business.

f. Documentation to Establish Financial Stability ([Documentation to Establish Financial Stability-DHS-7896-ENG](#))¹⁰: It is the [policy of the State of Minnesota](#) to make grants to organizations that are sufficiently financially stable to carry out the purpose of the grant. The information collected under this section will be used in State’s determination of the award of the contract. Responder must complete the “Documentation to Establish Financial Stability” form and submit the form along with the financial statements required with its Proposal.

4. RFP PROCESS

4.1 Timeline

ACTIVITY	DATE
State Register Notice/RFP Published on DHS Website	October 25, 2021
Questions for Responder’s Conference	November 19, 2021
Responder’s Conference Registration Deadline	November 19, 2021
Responder’s Conference	December 3, 2021
All RFP Questions Answered and Posted on DHS Website	January 20, 2022
Complete RFP Proposals Due	February 18, 2022
Notice of Intent to Contract	Anticipated May 9, 2022
Start of Contract	January 1, 2023

4.2 Access to the RFP

To access the RFP, click on the DHS Grants and RFPs Website link below.

<https://mn.gov/dhs/partners-and-providers/grants-rfps/>

¹⁰ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7896-ENG>

4.3 Responders' Conference

A Responders' Conference will be held on December 3, 2021, at 1:00 p.m. Central Time. The conference will serve as an opportunity for Responders to ask specific questions of State staff concerning the project. Oral answers given at the conference will be non-binding. Attendance at the Responders' Conference is not mandatory but is recommended. Responders will attend via WebEx call. Responders must register to attend the Responders' Conference.

Click on the following link to register: SNP_RFPs@state.mn.us. Provide the name, email address, organization and any needed accommodations for each attendee.

An invitation will be sent to all registered attendees no later than close of business December 1, 2021.

4.4 Responders' Questions

Responders' questions regarding this RFP must be submitted in writing prior to 4:00 p.m. Central Time on December 30, 2021. All questions must be emailed to SNP_RFPs@state.mn.us.

Other State personnel are NOT authorized to discuss this RFP with Responders before the Proposal submission deadline. **Contact regarding this RFP with any State personnel not listed above could result in disqualification.** The State will not be held responsible for oral responses to Responders.

Questions will be addressed in writing and posted to the DHS Procurement website located at: <https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/mcos/contract-information-forms-and-resources/>

Every effort will be made to provide answers, within fourteen (14) days of receiving a question. Responses to all RFP questions will be posted no later than January 20, 2022.

4.5 Proposal Submission

The proposal submission should include three (3) separate USB drives:

- One (1) complete original non-redacted copy labeled as "2023 SNBC RFP Proposal – Original";
- One (1) complete original redacted copy with the removal of trade secret information (refer to the Trade Secret Data Notification section) labeled as "2023 SNBC RFP Redacted Proposal"; and
- One (1) original non-redacted copy with the removal of the Disclosure of Ownership information labeled as "2023 SNBC RFP County Proposal" for county distribution.

Proposals must be physically received (not postmarked) by 4:00 p.m. Central Time on February 18, 2022 to be considered. Late Proposals will not be considered and will be returned unopened to the submitting party. Faxed or e-mailed Proposals will not be accepted.

The three (3) proposal copies must be submitted in a single sealed package or container and via USB drive only. USB Drives must not be encrypted or password protected. Do not submit paper copies.

Starting with the Table of Contents through the duration of the document, the Proposal page numbers must flow continuously in numeric order. The Proposal must also be bookmarked, single spaced, and in one continual complete searchable document. All sections must be labeled as referenced in the RFP. Sections must not be submitted in separate documents or folders on the USB Drive. Scanned documents included in the proposal are not acceptable due to search restrictions. The size and/or style of graphics, tabs, attachments, margin notes/highlights, etc. are not restricted by this RFP and their use and style are at the Responder's discretion. There will be a five (5) point deduction from the final score of any Proposal that does not comply with proposal submission formatting requirements.

All correspondence must be directed to Kristi Burt at the following email address:
SNP_RFPs@state.mn.us

The above-referenced packages must be delivered to:

Attention: Kristi Burt
Health Care Administration, Purchase and Service Delivery Division
Department of Human Services
444 Lafayette Road N.
St. Paul, MN 55155

It is solely the responsibility of each Responder to assure that its Proposal is delivered at the specific place, in the specific format, and prior to the deadline for submission. **Failure to abide by these instructions for submitting Proposals may result in the disqualification of any non-complying Proposal**

Trade Secret Data Notification

All materials submitted in response to this RFP will become property of the State and will become public record in accordance with Minnesota Statutes, section 13.591, after the evaluation process is completed. Pursuant to the statute, completion of the evaluation process occurs when the government entity has completed negotiating the contract(s) with the successful Responder(s). If a contract is awarded to the Responder, the State must have the right to use or disclose trade secret data to the extent otherwise provided in the MCO contract or by law.

If a Responder submits information in response to this RFP that it believes to be "business confidential" trade secret materials, as defined by the Minnesota Government Data Practices Act, Minnesota Statutes, section 13.37, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this proposal, the Responder must:

- a) Clearly mark each page in the proposal that contains trade secret information at the time the proposal is submitted with the words "**TRADE SECRET**" in capitalized, underlined and bolded type that is at least 20 point. The State does not assume liability for the use or disclosure of unmarked or unclearly marked trade secret data. The State will not consider any information to be trade secret if the entire response is marked as trade secret;
- b) Fill out and submit the "[Trade Secret Data Notice \(DHS-7015\)](#)," specifying the pages of the proposal which are to be restricted and justifying the trade secret designation for each item. If no material is being designated as protected, a statement of "None" should be listed on the form;

- c) Satisfy the burden to justify any claim of trade secret information. In order for a trade secret claim to be considered by the State, detailed justification that satisfies the statutory elements of Minnesota Statutes, section 13.37 and the factors discussed in *Prairie Island Indian Community v. Minnesota Dept. of Public Safety*, 658 N.W.2d 876, 884-89 (Minn. App. 2003) must be provided. Use of generic trade secret language encompassing substantial portions of the proposal or simple assertions of trade secret interest without substantive explanation of the basis thereof will be regarded as nonresponsive requests for trade secret exception and will not be considered by the State in the event a data request is received for proposal information; and
- d) Defend any action seeking release of the materials it believes to be trade secret and/or confidential, and indemnify and hold harmless the State, its agents and employees, from any judgments awarded against the State in favor of the party requesting the materials, and any and all costs connected with that defense. This indemnification survives the State’s award of a contract. In submitting a response to this RFP, the Responder agrees that this indemnification survives as long as the trade secret materials are in the possession of the State. The State is required to keep all the basic documents related to its contracts, including selected responses to RFPs, for a minimum of six years after the end of the contract. Non-selected RFP proposals will be kept by the State for a minimum of one year after the award of a contract, and could potentially be kept for much longer.

The State reserves the right to reject a claim if it determines Responder has not met the burden of establishing that the information constitutes a trade secret. The State will not consider prices or costs submitted by the Responder to be trade secret materials. Any decision by the State to disclose information designated by the Responder as trade secret will be made consistent with the Minnesota Government Data Practices Act and other relevant laws and regulations. If certain information is found to constitute a trade secret, the remainder of the proposal will become public; only the trade secret information will be removed and remain nonpublic.

The State also retains the right to use any or all system ideas presented in any proposal received in response to this RFP unless the Responder presents a positive statement of objection in the proposal. Exceptions to such Responder objections include: (1) public data, (2) ideas which were known to the State before submission of such proposal, or (3) ideas which properly became known to the State thereafter through other sources or through acceptance of the Responder's proposal.

5. PROPOSAL EVALUATION AND SELECTION

5.1 Overview of Evaluation Methodology

1. All responsive Proposals received by the deadline will be evaluated by the State. Proposals will be evaluated on “best value” as specified below. The evaluation will be conducted in three phases:

- a. Phase I Required Statements Review
- b. Phase II Evaluation of Proposal Requirements and Readiness Review
- c. Phase III Selection of the Successful Responder(s)

2. During the evaluation process until the 2023 contracts are executed, all information concerning the Proposals submitted, except for the name of the Responder(s), will remain non-public and will not be disclosed to anyone whose official duties do not require such knowledge.

3. Nonselection of any Proposals will mean that either another Proposal(s) was determined to be more advantageous to State or that State exercised the right to reject any or all Proposals. At its discretion, State may perform an appropriate cost and pricing analysis of a Responder's Proposal, including an audit of the reasonableness of any Proposal.

5.2 Evaluation Team

1. An evaluation team consisting of State and County staff will evaluate Responder Proposals.

2. State and professional staff, other than the evaluation team, may also assist in the evaluation process. This assistance could include, but is not limited to, the initial mandatory requirements review, contacting of references, or answering technical questions from evaluators.

3. State reserves the right to alter the composition of the evaluation team and their specific responsibilities.

4. The State as a participant in the federal Medicaid program must safeguard against conflicts of interest in the Medicaid procurement process. See 42 U.S.C. §§ 1396a (a) (4) and 1396u-2(d)(3); Minnesota Statutes, section 256B.0914. The State must ensure that a person who participates in the evaluation of the RFP responses does not have a conflict of interest as described in Minn. Stat. § 16B.98, subd.

3. Therefore, all evaluators and other staff will be required to sign a conflict of interest statement and confidentiality agreement in order to participate as a member of the evaluation team.

Pursuant to Minnesota Statutes, section 256B.0914: Failure to abide by the above restrictions could result in criminal prosecutions or a fine of \$50,000, or both, for each violation.

5. The county role in seeking Responders to provide services to people eligible for SNBC and Integrated SNBC within the proposed county is important in the development, approval and issuance of the RFP. The county also has the opportunity to review and score the proposals based on the identification of community needs and county advocacy activities and provide feedback on Responders' provider network(s). Pursuant to Minnesota Statutes, section 256B.69 subdivision 3a(a), the county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services.

5.3 Evaluation Phases

At any time during the evaluation phases, State may, at State's discretion, contact any Responder to (1) provide clarification of its Proposal or (2) obtain the opportunity to interview the proposed key personnel. Reference checks may also be made at this time. However, there is no guarantee that State will look for information or clarification outside of the submitted written Proposal. Therefore, it is important that the Responder ensure that all sections of the Proposal have been completed to avoid the possibility of failing an evaluation phase or having its score reduced for lack of information.

Phase I: Required Statements and Forms Review

The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified to move to Phase II.

Required Statement and Forms	Total Possible Points
Trade Secret Data Notification	P/F
Responder Information and Declarations	P/F
Disclosure of Ownership and Management Information	P/F
Exception to Model Contract and RFP Terms	P/F
Disclosure of Funding	P/F
Human Rights Compliance <ul style="list-style-type: none">• Workforce Certificate Information• Equal Pay Certificate	P/F
Documentation to Establish Financial Stability	P/F

2. Phase II: Evaluation of Proposal Requirements and Readiness Review

The Proposal Requirements will be evaluated on both a pass/fail basis and point factors.

Points have been assigned to the following component areas. For any item marked "Pass/Fail," if the proposal receives a fail, the proposal will be deemed non-responsive to Phase II and the proposal will not move on for consideration in Phase III.

Component	Total Possible Points
Service Delivery Plan including Executive Summary and Description of the Applicant Organization, but not including Section E, Care Coordination Model	P/F
Readiness Review	P/F
Financial Solvency	P/F
Provider Network Adequacy Review	P/F

The total possible points for these component areas are as follows:

Component	Total Possible Points
Professional Responsibility and Data Privacy	5 points; possible reduction of up to 5 points per item
Service Delivery Plan Section E, Care Coordination Model	10 points
Performance and Service Deliverables Section 1 – Continuity of Care/ Plan Transition Section 2 – Continuity of Care/Medicare Transition Section 3- Care Coordination Training and Support Section 4 – Member engagement and communication: stakeholder input Section 5- Substance Use Disorder (SUD) Section 6 - Maintaining Member Eligibility Section 7 – Improving Outcomes and Eliminating Disparities Section 8 – Transportation Access Section 9 – Dental Access	90 points total Section 1 – 10 points Section 2- 7 points Section 3- 10 points Section 4 – 7 points Section 5 – 10 points Section 6- 10 points Section 7 – 19 points Section 8 – 10 points Section 9 - 7 points
Other <ul style="list-style-type: none"> • Exceptions to Terms and Conditions • Formatting Requirements 	Possible Reduction of up to 5 points per item

The evaluation team will review the components of each responsive Proposal submitted. Each component will be evaluated on the Responder's understanding and the quality and completeness of the Responder's approach and solution(s) to the problems or issues presented.

After reviewing the Proposals, the members of the evaluation team will rate the Performance and Service Deliverables and Care Coordination Model according to the following scale:

Proposal Component Rating	Point Factor
Excellent	1
Good	0.75
Satisfactory	0.50
Poor	0.25
Unacceptable	0

Upon determining which of the above Ratings best describes the component being rated, the total possible points available for the component will be multiplied by the corresponding point factor.

EXAMPLE: A “good” rating (0.75) of a section that is worth 10 points would receive a score of 0.75 times the 10 possible points or 7.5 points.

A proposal must receive a final total score of 50 or greater to pass to Phase III. The State reserves the right to evaluate the strength of the proposal with respect to individual counties and to make a partial award in the event that the quality of Responder's proposal is poorer in some counties than others.

Up to five (5) points will be deducted from the overall score for any exception to the State's terms and conditions (including those found in the current [model contract](#)) that is listed by the Responder in the Exceptions to Terms and Conditions and for any CMS sanction listed by the Responder in Section 10 of the Performance and Service Deliverables.

All component scores will then be added together to create a Proposal's total score.

Readiness Review

In accordance with Federal Regulation 42 C.F.R. § 438.66(d)(1), the State must assess the readiness of MCO entities when the MCO has not previously contracted with the State or when the MCO will be providing benefits to a new eligibility group. Any Responder that meets these criteria will be subject to a readiness review of the elements outlined in 42 C.F.R. § 438.66(d)(4).

Responders may also be subject to further readiness review after proposal selection if any of the following conditions are met:

- The Responder's total member enrollment would increase by 30% or more by contracting with the State as a result of this RFP.
- The Minnesota Department of Health (MDH) has undertaken regulatory review related to the Responder's solvency status and meets one of the criteria under the Financial Solvency section below that may require a readiness review.

Financial solvency readiness reviews of any Responder will occur during the proposal review process. Further readiness review will continue after selection of Responders. Successful completion of all items in the readiness review is required for successful contract negotiations. DHS will contact qualifying Responders to coordinate the readiness review.

Financial Solvency

Responders must meet the solvency standards established by the State for health maintenance organizations (HMOs) or be licensed or certified by the State as a risk bearing entity under Minnesota Statutes, section 256B.69, subdivision 2(b). As part of the RFP review process, DHS will ask the Minnesota Department of Health (MDH) to report on the financial solvency status of all Responders.

Results based on MCO solvency information.

- If the Responder is under no regulatory action, the Responder will pass the solvency review.
- If the Responder is at "mandatory control level RBC" as described in Minnesota Statutes, sections 60A.50-592 or "authorized control level RBC" and is subject to the action under Minn. Stat. § 60A.54, subd. 2(2), it will fail the solvency review.
- If the Responder is under regulatory action and has submitted an RBC plan that has not been approved by MDH before the deadline for responses to this RFP, it will fail solvency review.

- If the Responder is under regulatory action but has an approved RBC plan, it will pass solvency review, and will be subject to a readiness review to determine whether the requirements of the contract can be fulfilled.
- If the Responder is under additional monitoring by MDH related to the Responder's solvency, the Responder may be subject to a readiness review to determine whether the requirements of the contract can be fulfilled.

3. Phase III: Selection of the Successful Responder(s)

- a. Only Proposals found to be responsive under Phases I and II will be considered in Phase III.
- b. The evaluation team will review the scoring in making its recommendations of the successful Responder(s). Other factors upon which the proposals will be evaluated by the State include, but are not limited to, the following:
 - The evaluation criteria developed by the State and counties.
 - The Responder's ability to meet all requirements contained in this RFP, which includes providing all health care services and tasks required in the current model contract.
 - Number of potential Responders and availability of providers in the Responder's proposed service areas.
 - Consideration of transitions of enrollees between MHCP programs.
- c. The State may submit a list of detailed comments, questions, and concerns to one or more Responders after the initial evaluation. The State may require said response to be written, oral, or both. The State will only use written responses for evaluation purposes. The total scores for those Responders selected to submit additional information may be revised as a result of the new information.
- d. The evaluation team will make its recommendation based on the above-described evaluation process. The successful Responder(s), if any, will be selected approximately twelve (12) weeks after the Proposal submission due date.
- e. The final award decision will be made by the Commissioner of Human Services (the Commissioner) or authorized designee. The Commissioner or authorized designee may accept or reject any recommendation of the evaluation team.
- f. Any dispute between the State and the counties about the MCO selection process will be reviewed by a three person mediation panel as provided in Minnesota Statutes, section 256B.69, subdivision 3a(d). The Commissioner will resolve any disputes taking into account the recommendations of this panel.

5.4 Contract Negotiations and Unsuccessful Responder Notice

If a Responder(s) is selected, the State will notify the successful Responder(s) in writing of their selection and the State's desire to enter into contract negotiations. Until the State successfully completes negotiations with the selected Responder(s), all submitted Proposals remain eligible for selection by the State. Data created or maintained by the State as part of the evaluation process (except trade secret

data as defined and classified in Minn. Stat. § 13.37) will be public data when contract negotiations have been successfully completed. If the State determines that it is unlikely that a Responder will be selected for contract negotiations, the State may, as a courtesy, notify the Responder that it has not been selected for contract negotiations.

In the event contract negotiations are unsuccessful with the selected Responder(s), the evaluation team may proceed with the next highest recommended Responder(s).

After the State and chosen Responder(s) have successfully negotiated a contract, the State will notify the unsuccessful Responders in writing that their Proposals have not been accepted. All public information within Proposals will then be available for Responders or members of the public to review, upon request.

6. REQUIRED CONTRACT TERMS AND CONDITIONS

A. Requirements. Each Responders must be willing to comply with all State and federal legal requirements regarding the performance of the grant contract. The full requirements are set forth throughout this RFP and are contained in the attached model contract in Appendix A. However, if there are State or Federal legal requirements not included in this RFP or appendices, each Responder must be willing to comply with those requirements. The attached model contract should be reviewed for the terms and conditions that will likely govern any resulting contract from this RFP. Although this RFP establishes the basis for Responder Proposals, the detailed obligations and additional measures of performance will be defined in the final negotiated managed care organization contract.

B. Governing Law/Venue. This RFP and any subsequent contract must be governed by the laws of the State of Minnesota. Any and all legal proceedings arising from this RFP or any resulting contract in which the State is made a party must be brought in the State of Minnesota, District Court of Ramsey County. The venue of any federal action or proceeding arising here from in which the State is a party must be the United States District Court for the State of Minnesota in Ramsey County.

D. Preparation Costs. The State is not liable for any cost incurred by a Responders in the preparation and production of a Proposal. Any work performed prior to the issuance of a fully executed grant contract will be done only to the extent the Responder voluntarily assumes risk of non-payment.

E. Contingency Fees Prohibited. Pursuant to Minnesota Statutes, section 10A.06, no person may act as or employ a lobbyist for compensation that is dependent upon the result or outcome of any legislation or administrative action, including the outcome of this RFP or any contract resulting from it.

F. Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion. Federal money will be used or may potentially be used to pay for all or part of the work under the contract, therefore the Responder must certify the following, as required by the regulations implementing Executive Order 12549.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Covered Transactions

Definitions:

- “Lower tier participant” or “participant” for the purposes of this section refers to the Respondent managed care organization.
- “Subcontractor” to a lower tier participant means the definition in 42 C.F.R. § 455.101.

A. Instructions for Certification

1. By signing and submitting this proposal, the Responder (a prospective lower tier participant) is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverages sections of 2 C.F.R. parts 180 and 376 (rules implementing Executive Order 12549). The Responder may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this response that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized in writing by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “A. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions, including subcontractor contracts and solicitations.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under

48 C.F.R. part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction (including subcontractor contracts) with a person who is proposed for debarment under 48 C.F.R. part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

B. Certification

1. The prospective lower tier participant certifies, by signing and submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

G. Contingency of Operations Planning Requirement

Functions identified under this Request for Proposal have been designated as Priority 1 or Priority 2 services under the Minnesota Department of Human Services' Continuity of Operations Plan. Due to this designation, the successful Responder will be required to develop a contingency of operations plan to be implemented in the event of a gubernatorial or Commissioner of the Minnesota Department of Health declared health emergency. The successful Responder will be expected to have a contingency of operations plan available for inspection by the State upon request. The contingency of operations plan shall do the following:

- a. Ensure fulfillment of Priority 1 or Priority 2 obligations under the contract;
- b. Outline procedures for the activation of the contingency plan upon the occurrence of a governor or commissioner of the Minnesota Department of Health declared health emergency;
- c. Identify an individual as its Emergency Preparedness Response Coordinator (EPRC), the EPRC shall serve as the contact for the State with regard to emergency preparedness and response issues, the EPRC shall provide updates to the State as the health emergency unfolds;
- d. Outline roles, command structure, decision making processes, and emergency action procedures that will be implemented upon the occurrence of a health emergency;
- e. Provide alternative operating plans for Priority 1 or Priority 2 functions;

- f. Include a procedure for returning to normal operations; and
- g. Be available for inspection upon request.

H. Accessibility Standards. Any information systems, tools, information content, and/or work products, including the response to this solicitation/contract, applications, web sites, video, learning modules, webinars, presentations, etc., whether commercial off-the-shelf (COTS) or custom, purchased or developed, must comply with the Minnesota IT Accessibility Standards effective September 1, 2010, as updated on June 14, 2018. This standard requires in part, compliance with the Web Content Accessibility Guidelines (WCAG) 2.0 (Level AA) and Section 508 Subparts A-D.

Information technology deliverables and services offered must comply with the [MN.IT Services Accessibility Standards](#).¹¹ (The relevant requirements are contained under the “Standards” tab at the link above.) Information technology deliverables or services that do not meet the required number of standards or the specific standards required may be rejected and may not receive further consideration.

7. STATE’S AUTHORITY

1. The State may:
 - A. Reject any and all Proposals received in response to this RFP;
 - B. Disqualify any Responder whose conduct or Proposal fails to conform to the requirements of this RFP;
 - C. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation or mediation, and duplicate all public information in response to data requests regarding the Proposal;
 - D. Select for contract or for negotiations a Proposal which best represents “best value” as defined in Minnesota Statutes, section 16C.02, subdivision 4 and in this RFP document;
 - E. Consider a late modification of a Proposal if the Proposal itself was submitted on time and if the modifications were requested by the State, and the modifications make the terms of the Proposal more favorable to the State, and accept such Proposal as modified;
 - F. At its sole discretion, reserve the right to waive any non-material deviations from the requirements and procedures of this RFP;
 - G. Negotiate as to any aspect of the Proposal with any Responder and negotiate with more than one Responder at the same time, including asking for Responders’ “Best and Final” offers;

¹¹ <https://mn.gov/mnit/about-mnit/accessibility/>

- H. Extend the grant contract, in increments determined by the State, not to exceed a total contract term of five years;
 - I. Cancel the RFP at any time and for any reason with no cost or penalty to the State; and
 - J. The State will not be liable for any errors in the RFP or other responses related to the RFP.
2. If federal funds are used in funding a contract that results from this RFP, in accord with 45 C.F.R. § 92.34, for Works and Documents created and paid for under the contract, the U.S. Department of Health and Human Services will have a royalty free, non-exclusive, perpetual and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the Works or Documents created and paid for under a resulting contract for federal government purposes.

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APPENDIX: DOCUMENTS, FORMS AND LINKS

Many of the documents, forms and links for your RFP submission are available on the [Managed Care Organizations \(MCO\) contract information, forms and resources](#) website for ease of access. Scroll to the Procurement Section in the middle of the page and expand the section [2023 Special Needs BasicCare RFP Information](#) . The following list will appear.

Background information:

1. [2021 SNBC Model Contract](#)
2. [County Demographics](#)
3. [County Specific Information](#)

Proposal Components:

4. [SNBC Guiding Principles To Design, Implement, Evaluate, and Improve Services For Persons With Disabilities](#)
5. Professional Responsibility and Data Privacy
 - a. [Data Privacy](#)
 - b. [MN-IT Vendor Security Compliance](#)
6. Provider Network Adequacy Review
 - a. [SNBC network adequacy attestation](#)
 - b. [Provider Network Listing Template](#)
 - c. [SNBC Geographic Access Map Specifications](#)
7. Performance and Service Deliverables
 - a. [New Employee Utilization report sample](#)
8. Required Statements and Forms
 - a. Responder Information and Declarations
 - i. [Responder Information/Declarations Form](#)
 - ii. [Minnesota SNBC County List](#)
 - b. Disclosure of Ownership and Management Information
 - i. [Disclosure of Ownership Reporting Template](#)
 - ii. [Disclosure of Ownership Report Attestation](#)
 - c. [Exceptions to Model Contract and RFP Terms](#)
 - d. [Disclosure of Funding Form](#)
 - e. Human Rights Compliance:
 - i. [Workforce Certificate Information](#)
 - ii. [Equal Pay Certificate](#)
 - f. [Documentation to Establish Financial Stability](#)
 - g. [Trade Secret Data Notification](#)

Sign up for Managed Care updates at the bottom of the webpage to receive notification when this page is updated with any new procurement information.