

**Request for Proposals**

**Section A: Scope of Work**

**External Quality Review Organization (EQRO) and Quality Improvement Organization (QIO) Contractor**

**RFP Number: 8070001252**

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**Issue Date: December 1, 2020**

**Proposal Due Date: January 12, 2021**

Section A: Scope of Work

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**SECTION A. SCOPE OF WORK**

# A.1 Calendar of Events

***All dates are estimates and subject to change.***

|  |  |
| --- | --- |
| **ACTIVITY** | **DATE** |
| RFP available on OHCA website/email Bidders | Tuesday, December 1, 2020 |
| RFP Questions Due by 3:00 p.m. Central | Friday, December 11, 2020 |
| RFP answers available on website by 3:00 P.M. Central | Tuesday, December 22, 2020 |
| Proposals Due to OHCA by 3:00 p.m. Central | Tuesday, January 12, 2021 |
| Oral Presentations/Interviews (optional)  At OHCA, by phone or video conferencing | Monday, January 25, 2021 |
| Award of Contract | Friday, January 29, 2021 (Estimated) |
| Operations Begin | Thursday, April 1, 2021 |

# A.2 General Information

## Introduction

* 1. The Oklahoma Health Care Authority (OHCA) is issuing this Request for Proposal (RFP) for the following services: External Quality Review Organization (EQRO) and Quality Improvement Organization (QIO) Contractor. As described in greater detail in Section A.3, the OHCA currently contracts with service providers on a non-risk basis but is in the process of contracting with Managed Care Entities (MCEs) for a portion of the Medicaid program. Going forward, the OHCA will require EQRO services for the MCE program and will continue to require QIO services.
  2. The Oklahoma Health Care Authority (OHCA) is issuing this Request for Proposal (RFP) for the following services: External Quality Review Organization (EQRO) and Quality Improvement Organization (QIO) Contractor.
  3. Bidders may submit a proposal to provide the services described in the RFP.

## Contract Overview

1. The OHCA intends to award a single Contract but reserves the option of awarding multiple contracts if deemed in the best interest of the State.
2. Though multiple awards are possible, the OHCA seeks to minimize the number of awards to reduce the number of implementations, ensure the work can be effectively divided among contractors, ensure the funding is available to support ongoing contractor operations, and there is enough work for each contractor to perform.

## Project Goals

The OHCA’s seeks to retain the services of a Contractor to comply with all state and federal requirements and support the OHCA’s goals of promoting high quality care and the appropriate utilization of healthcare services.

## Mandatory Provisions

1. The Bidder or its subcontractor(s) shall:
   * 1. Meet all federal requirements to serve as an EQRO as specified by 42 CFR 438.354;
     2. Have experience providing EQR services on behalf of at least one state;
     3. Be certified as a QIO or QIO-like entity (or be in the process of receiving QIO or QIO-like certification);
     4. Have experience providing medical and utilization review services on behalf of at least one state;
     5. Have a minimum of three (3) years of experience providing the EQR and utilization review services; and
     6. Meet additional Contractor requirements as specified in Section A.5 Contractor Requirements.
2. The proposed solution shall:
3. Be expandable, as needed, to meet program goals and objectives;
4. Be flexible to comply with, and advance, State and Federal policy changes; and
5. Be collaborative with OHCA staff and other OHCA vendors to advance program goals and objectives.

## Budget

1. The budget shall be based on the competitive procurement process.
2. Value-Based Purchasing
3. A portion of Contractor’s payment shall be subject to value-based purchasing terms, as defined in the payment and pricing sections of the Contract;
4. Contractor shall earn value-based payments by meeting OHCA-approved performance targets;
5. Contractor shall monitor and report its status with respect to performance targets using OHCA-approved methodologies;
6. Value-based payments that are not earned shall be retained by the OHCA; and
7. The OHCA shall have sole authority for determining whether Contractor has met performance targets.

## Contract Term

The initial contract period shall commence upon contract execution and end on June 30, 2021. The OHCA shall have the option to renew the contract for up to six (6) additional one-year periods.

## Definitions/Acronyms Specific to this RFP

1. **Business Days** - Defined as Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.
2. **Calendar Days** - Defined as all seven days of the week, including State of Oklahoma holidays.
3. **CCS –** Certified Coding Specialist
4. **CHIP –** Children’s Health Insurance Program
5. **CMS -** Centers for Medicare and Medicaid Services
6. **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** – A program and related survey tools developed by the Agency for Healthcare Research and Quality (AHRQ) to evaluate patient experience with the health care system.
7. **Contract** - As a result of receiving an award from the OHCA and successfully meeting all Contractor review requirements, the agreement between the Contractor and the OHCA, under which the Contractor will provide EQRO/QIO services to SoonerCare members and be paid by the OHCA, and which shall consist of the Contract itself and any Contract addenda, appendices, attachments and/or amendments.
8. **Contractor** – An organization with which the OHCA has entered into a binding agreement for the purpose of providing services as specified in the RFP.
9. **CPC** – Certified Professional Coder
10. **Days** - Calendar days unless otherwise specified.
11. **DBM** – Dental Benefits Manager
12. **External Quality Review (EQR) -** The analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries.
13. **External Quality Review Organization (EQRO) -** An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs External Quality Review and other EQR-related activities as set forth in 42 CFR 438.358.
14. **EQR-related activities** – Activities addressed in the CMS EQR Protocol.
15. **Gross and Flagrant Violation** - a violation of an obligation resulting from inappropriate or unnecessary services, service that do not meet recognized professional standards of care, or QIO. The violation must have occurred in one or more instances that present an imminent danger to the health safety, or well-being of a program patient or place the program patient unnecessary in high risk situations. (42 CFR 476.1).
16. **Healthcare Effectiveness Data and Information Set (HEDIS)** – A tool supplied by the National Committee for Quality Assurance (NCQA) and used by managed care entities (MCEs) to measure performance on important dimensions of care and service. This information set contains a number of measures designed to evaluate quality of care in a standardized fashion that allows for comparison between MCEs.
17. **MCO -** Managed Care Organization
18. **Managed Care Entity (MCE) –** For purposes of this RFP and project, includes both MCOs and PAHPs (DBMs).
19. **Member** - A member is an individual enrolled in the Oklahoma Medicaid program.
20. **NCQA** – National Committee for Quality Assurance
21. **Oklahoma Health Care Authority (OHCA)** -The single State Agency for Medicaid in Oklahoma and the Agency with direct oversight of the Contractor’s services.
22. **Outcomes** - Changes in member health, functional status, satisfaction or goal achievement that result from health care or supportive services.
23. **PAHP –** Prepaid Ambulatory Health Plan (related to Dental Benefits)
24. **PAM –** Payment Accuracy Measurement
25. **Performance Improvement Projects** – targeted initiatives occurring in support of the OHCA Quality Improvement Program and designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and that include the following elements:
    * 1. Measurement of performance using objective quality indicators;
      2. Implementation of interventions to achieve improvement in the access to, and quality of care;
      3. Evaluation of the effectiveness of the interventions; and
      4. Planning and initiation of activities for increasing or sustaining improvement.
26. **QIO –** Quality Improvement Organization
27. **QIO-Like Entity –** organization that meets the requirements of Section 1152 of the Social Security Act and is certified by CMS to provide QIO-like services.
28. **Quality of Care Concern** - a concern that care provided did not meet a professionally recognized standard of health care. A general quality of care review or a beneficiary complaint review may cover a single or multiple concerns. (42 CFR 476.1)
29. **Significant Quality of Care Concern (Serious Risk)** - a determination that the quality of care provided did not meet the standard of care and, while not a gross and flagrant or substandard violation of the standard, represents a noticeable departure from the standard that could reasonably, be expected to have a negative impact on the health of a beneficiary. (42 CFR 476.1)
30. **Substantial Violation in a Substantial Number of Cases** - a pattern of providing care that is inappropriate, unnecessary, does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the QIO. (42 CFR 1004.1(b))
31. **Shall** - A verb used to designate duties that will be a required condition of the Contract. Failure of a Contractor to perform a duty required as a condition of the Contract will be considered breach of Contract.

# A.3 SoonerCare Background Information

## Overview: Oklahoma Health Care Authority and SoonerCare

The OHCA is the state agency that administers the Oklahoma Medicaid Program known as SoonerCare. Medicaid is a Federal and State entitlement program that provides funding for medical benefits to certain low-income individuals who have inadequate or no health insurance coverage. Medicaid covers basic health and long-term care services based upon income and/or resources. Created by Title XIX of the Social Security Act of 1965, Medicaid is administered at the Federal level by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). CMS established and monitors certain requirements concerning funding, eligibility standards, scope and quality of medical services. States have the flexibility to determine some aspects of their own program, such as setting Provider (an individual or entity contracted with the OHCA to provide healthcare services to enrolled Members) reimbursement rates and determining the eligibility requirements and benefits offered within certain Federal parameters.

SoonerCare is the State of Oklahoma’s Medicaid program. The OHCA is the single state agency responsible for administration of SoonerCare. Since 1995, SoonerCare has operated under Section 1115 demonstration authority granted by the Centers for Medicare and Medicaid Services (CMS). SoonerCare services are currently delivered through coordinated care models including patient centered medical homes (PCMH), Health Access Networks (HANs) and the SoonerCare Health Management Program (HMP). All SoonerCare Eligibles qualify to receive services through these models, with the exception of the following:

* Dual Eligible Individuals;
* Individuals residing in an institution or nursing home;
* §1915(c) Waiver enrollees;
* Individuals infected with tuberculosis covered under §§ 1902(a)(10)(A)(ii)(XII) and 1902(z)(1) of the Act;
* Individuals eligible as a Former Foster Care Child under 42 CFR § 435.150;
* Pregnant women with incomes between 134% and 185% FPL; and
* Individuals with other creditable coverage.

Following is a high-level summary of the current care coordination models available to SoonerCare Eligibles.

* + Patient Centered Medical Home (PCMH): A statewide enhanced Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers to serve as PCMHs. PCMH Providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet. The OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers also can earn “SoonerExcel” quality incentives for meeting or exceeding various quality-of-care targets within an area of clinical focus selected by the OHCA.
  + Health Access Network (HAN): Non-profit, administrative entities that work with affiliated Providers to coordinate and improve the quality of care provided to Eligibles. The HANs employ care managers to provide telephonic and in-person care management and care coordination to Eligibles with complex health care needs who are enrolled with affiliated PCMH Providers. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. For example, the HANs have implemented evidence-based protocols for care management of aged, blind and disabled (ABD) Eligibles with, or at risk for, complex/chronic health conditions, as well as TANF and related Eligibles with asthma and diabetes, among other conditions.
  + Health Management Program (HMP): The SoonerCare HMP is an initiative developed to offer care management to Eligibles most at-risk for chronic disease and other adverse health events. The program is administered by the OHCA and is managed by a vendor selected through a competitive procurement. The SoonerCare HMP serves Eligibles ages four (4) through sixty-three (63) who are not enrolled with a HAN and have one or more chronic illnesses and are at high risk for adverse outcomes and increased health care expenditures. The program is holistic, rather than disease specific, but prominent conditions of Eligibles in the program include asthma, cardiovascular disease, chronic obstructive pulmonary disorder, diabetes, heart failure and hypertension.

On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income is at or below 138% FPL. Medicaid expansion will go into effect on July 1, 2021.

Additional information regarding SoonerCare, including the Oklahoma Children’s Health Insurance Program (CHIP), can be found on the OHCA website: <https://okhca.org/>

## Overview: SoonerSelect

The OHCA intends to achieve the following payment and delivery system reform goals through its comprehensive managed care approach, SoonerSelect:

* Improve health and oral health outcomes for Oklahomans;
* Reduce adult and childhood obesity;
* Reduce substance abuse;
* Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;
* Improve SoonerCare Eligibles’ satisfaction;
* Contain costs through better coordinating services; and
* Increase cost predictability to the state.

The OHCA intends to contract on a statewide basis with managed care organizations (MCOs) to deliver risk-based managed care services to SoonerCare Children, Deemed Newborns, Pregnant Women, Parent and Caretaker Relatives, and Expansion Adults. OHCA also intends to contract on a statewide basis with prepaid ambulatory health plans (PAHP) to deliver risk-based dental benefits to these same population groups.

The OHCA intends to award statewide Contracts to a minimum of three Contractors. At its sole discretion, the OHCA may award more than three Contracts.

The OHCA also intends to contract with one of the selected MCOs to deliver statewide risk-based managed care services for SoonerCare Eligibles who are Former Foster Children, Juvenile Justice Involved, in Foster Care or Children Receiving Adoption Assistance.

Enrollment of SoonerCare Eligibles into the SoonerSelect program will be effective October 1, 2021.

The OHCA may consider enrollment of additional SoonerCare eligibility groups into the SoonerSelect program in future years. Expansion of enrolled populations would be implemented through the MCO procurement or Contract amendment process.

Additional information regarding SoonerSelect, including the SoonerSelect Request for Proposals for MCOs and PAHPs, can be found on the OHCA website in the Procurement section.

# A.4 Contract Governance

The OHCA and Contractor both have key roles for a successful Contract. OHCA takes an active role during Contract implementation. A Governance process that includes the OHCA and Contractor is the most successful. Summaries of the OHCA’s and Contractor’s roles and responsibilities follow.

## OHCA Roles and Responsibilities

The OHCA will coordinate and monitor project activities and make OHCA staff resources available as required to support the Contract. During the entire lifecycle of the Contract, the OHCA will:

1. Define the goals and objectives of the Contract and services throughout implementation and ongoing operations;
2. Communicate the goals, objectives, and ongoing status of the Contract to all stakeholders;
3. Work with stakeholders to identify and monitor project activities, project risks and appropriate mitigation approaches related to the Contract;
4. Monitor the program management approach that will govern the Contract;
5. Review the draft deliverables and final deliverables developed by the Contractor and provide feedback, request changes, and provide final review until the OHCA is satisfied with the resulting deliverable;
6. Review and approve or reject final deliverables developed and revised by the Contractor;
7. Provide access to OHCA management and Subject Management Experts (SMEs) for the approval of the deliverables required to meet the goals and objectives of the program;
8. Coordinate data exchanges and provide available data to support Contractor’s project activities; and
9. Perform additional activities proposed by the Contractor and acceptable to the OHCA.

## Contractor Roles and Responsibilities

The Contractor shall:

1. Provide all staff necessary to perform the services required under this RFP;
2. Provide office space, computer hardware and software necessary to perform the services required under this RFP;
3. Adhere to all state and federal laws, regulations and policies;
4. Ensure that resources are available to complete all project activities in a timely and accurate manner;
5. Work collaboratively with the OHCA to advance the goals and objectives of the program;
6. Meet all contractor requirements as specified in Sections A.5 of this RFP; and
7. Conduct quarterly meeting with the OHCA and provide status update report and projected activities to be completed in the next quarter.

# A.5 Contractor Requirements

Contractor shall meet all of specified requirements in the following areas, as defined further in this section of the RFP:

* Organization
* Staffing
* Project Activities
* Data Management and Security
* Reporting

## Organization

Contractor, in addition to any subcontractors, shall:

a. Have the staff, resources and skills to serve as an EQRO as specified in 42 CFR 438.354(b);

Meet the requirements for independence as specified in 42 CFR 4388.54(c)

Be certified as a QIO or QIO-like entity (or be in the process of receiving CMS certification);

Be National Committee for Quality Assurance (NCQA)-certified to conduct Healthcare Effectiveness Data and Information Set (HEDIS) audits;

Be an NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor;

Maintain an office, no more than 25 miles from the OHCA office, from which, at a minimum, staff as designated in RFP Section A.5.2 physically perform the majority of their daily duties and responsibilities, and a major portion of the Contractor’s operations take place;

Ensure the location of any staff or operational functions outside of Oklahoma does not compromise the delivery of contracted services. The Contractor shall be responsible for ensuring all staff functions conducted outside of Oklahoma are readily reportable to the OHCA to ensure such location does not hinder the OHCA’s ability to monitor the Contractor’s performance and compliance with Contract requirements;

Have adequate project management, monitoring and quality oversight tools and controls in place to ensure the accurate and timely completion of all project activities and deliverables;

Have sufficient physical, technological, and financial resources to conduct all project activities; and

Enforce tobacco-free policies covering 100% of the Contractor’s offices statewide. This is an evidence-based intervention for smoking cessation as tobacco free policies create environments that make it much easier to quit and stay quit;

## Staffing

Contractor shall maintain adequate staffing of qualified and appropriately trained individuals to meet all contract requirements. Contractor’s project staffing shall include, at a minimum, the following positions:

* + - Project Director
    - Project Manager
    - Medical Director
    - Doctors and other qualified clinicians
    - Certified Coders
    - Nurse Reviewers
    - EQR Reviewers (non-clinical)
    - IT/Data Manager
    - PhD Statistician

1. Key Personnel

The following positions are designated as Key Personnel:

* Project Director
* Project Manager
* Medical Director
* PhD Statistician

Contractor shall not change the designation of the Key Personnel or assign staff to Key Personnel positions without prior approval from the OHCA.

1. Location of Staff

The majority of project activities shall be performed by project staff assigned to Contractor’s office located within 25 miles of the OHCA office. The Contractor may maintain certain staff throughout Oklahoma in order to best perform contracted services.

1. Staff Qualifications and Roles/Responsibilities

The minimum qualifications as well as the roles and responsibilities for designated staff position are presented in the table below.

|  |  |
| --- | --- |
| **Project Director** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Minimum of 5 years of direct program oversight for EQR-related services and/or QIO services on behalf of a state Medicaid client. * Authorized to legally bind the Contractor * Authorized to allocate Contractor resources as needed to complete project activities * Available by telephone or in-person, as requested by the OHCA | * Ensure for the timely and accurate completion of all project activities, including project deliverables * Ensure adequate resources are available * Ensure compliance with contract standards and all relevant federal and state laws, regulations and policies * Identify and resolve any issues related to performance * Meet with the OHCA staff, as requested * Meet with stakeholders, as requested * Participate in quality forums, as requested |
| **Project Manager** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Minimum of 5 years of experience related to management of EQR-related services and/or QIO services * Authorized to make day-to-day decisions * Fully dedicated to the Oklahoma EQRO/QIO project throughout the duration * Located in Oklahoma throughout the duration of the project (unless waived by the OHCA) | * Primary point of contact for activities related to contract implementation and administration * Coordinate and report on project implementation activities * Manage discussions and correspondence between the OHCA and the Contractor, including status reporting, scheduling and the OHCA’s requests for information * Coordinate onsite/virtual status meetings, as well as interim meetings as needed * Develop agenda and prepare minutes for each meeting * Advise the OHCA regarding best practices and recommend modifications to business processes to improve the overall program. * Attend and/or present at stakeholder meetings * Organize and facilitate quality forums |
| **Medical Director** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Oklahoma-licensed MD or DO in good standing * Located in Oklahoma throughout the duration of the project (unless waived by the OHCA) | * Provide medical direction in the performance of all aspects of the program * Undertake practice education and interventions, when necessary to address performance-related issues or clinical concerns * Attend local meetings, as needed |
| **Dental Director** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Oklahoma-licensed dentist in good standing * Located in Oklahoma throughout the duration of the project (unless waived by the OHCA) | * Provide clinical direction in the performance of all aspects of the program related to dental care * Undertake practice interventions, when necessary to address performance-related issues or clinical concerns * Attend local meetings, as needed |
| **Doctors and Clinicians** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Oklahoma-licensed physicians, dentists and other practitioners, across all specialty types, to support project activities | * Review medical records * Make determinations regarding medical necessity, quality and DRG findings * Peer review, when necessary * Attend quality and/or Medical Education and Intervention meetings |
| **Certified Coders** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Minimum of two years of experience performing DRG validation * CPC and/or CCS-certified * Majority of DRG validation and functions performed within Oklahoma | * Review medical claims and records * Report findings * Participate in meetings with OHCA, providers, MCOs and other stakeholders, as requested |
| **Nurse Reviewers** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Minimum of two years of experience performing EQR-related services or utilization and quality reviews * Majority of review functions performed within Oklahoma * Registered Nurse licensed in state of Oklahoma | * Review medical claims and medical records * Report findings * Participate in meetings with OHCA, providers, MCOs and other stakeholders, as requested |
| **EQR Reviewers (non-clinical)** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Minimum of two years of experience performing EQR-related services or three years of experience in quality/performance monitoring of healthcare operations/services * Majority of review functions performed within Oklahoma | * Perform EQR services in compliance with CMS Protocols and contract standards * Participate in meetings with OHCA, providers, MCOs and other stakeholders, as requested |
| **IT/Data Manager** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Located in Oklahoma throughout the engagement (unless waived by the OHCA) * Minimum of 3 years of information technology or related management experience for a government or private sector health care payer | * Coordinate and manage data interfaces and exchanges * Manage the collection, analysis and maintenance of all data * Ensure compliance with data security and privacy requirements |
| **PhD Statistician** | |
| **Qualifications** | **Roles and Responsibilities** |
| * Minimum of three years of experience evaluating health care data * Doctorate degree in statistics, public health policy or related field | * Develop sampling and data analysis plans * Validate accuracy and completeness of data sets and findings as reported by third parties * Validate statistical validity of all data findings |

## Project Activities

1. Contractor shall provide the following services:

* Perform annual EQR and prepare annual EQR Technical Report;
* Perform all mandatory EQRO Protocol activities as defined under 42 CFR 438.358, in accordance with CMS EQR Protocols;
* Perform optional EQRO Protocol activities, at the OHCA’s discretion, as defined under 42 CFR 438.358, in accordance with CMS EQR Protocols;
* Perform Information Systems Capabilities Assessment (ISCA);
* Provide utilization and quality of care reviews, and DRG validation (QIO services);
* Support the OHCA’s quality improvement initiatives; and
* Assist the OHCA with MCO and/or DBM readiness reviews, as requested.

Annual EQR and EQR Technical Report

Contractor shall perform the EQR on an annual basis, in accordance with federal Medicaid and CHIP requirements. Contractor shall prepare an annual report that presents findings for the annual EQR for all participating MCO and DBM entities.

The annual EQR shall be conducted on a State Fiscal Year (July 1-June 30) basis.

The Annual EQR Technical Report shall meet the requirements of 42 CFR 438.364 and in accordance with CMS guidelines, the annual technical report must include:

* The results of the EQR-related activities;
* The EQRO’s assessment of each managed care plan’s strengths and weaknesses related to quality, timeliness and access;

Recommendations for improving the quality of health care services furnished by each managed care plan and recommendations for how the state can target goals and objectives in the State quality strategy;

* Methodologically appropriate, comparative information about all managed care plans; and
* An assessment of the degree to which each managed care plan has addressed the recommendations for quality improvement made by the EQRO during the previous year’s EQR.

The Annual EQR Technical Report is due to CMS on April 30th of each year. A draft EQR Technical Report shall be submitted to the OHCA no later than February 28th of each year.

c. CMS-Mandated EQR Activities

Contractor shall perform the following mandatory EQR activities:

* Protocol 1 - Validation of Performance Improvement Projects
* Protocol 2 - Validation of Performance Measures
* Protocol 3 - Review of Compliance with Medicaid and CHIP Managed Care Regulations
* Protocol 4 - Validation of Network Adequacy

Subject to meeting the nonduplication requirements in federal regulations at 42 CFR 438.360, the OHCA intends to use information from Medicare and private accreditation reviews in lieu of generating information through Protocols 1 through 3. If nonduplication is applicable, Contractor shall be responsible for assessing the completeness of information from the accreditation review to evaluate the extent to which nonduplication applies. Contractor shall perform any required EQR-related activities for all requirements where nonduplication is not applicable.

Under the SoonerSelect program requirements, MCOs and DBMs must be accredited within 18 months of contract award and are required to validate performance measures using an NCQA-certified auditor.

Validation of Network Adequacy (Protocol 4) is not a mandatory EQR-related activity until 1 year from the issuance of Protocol 4 by CMS. However, the OHCA intends to include validation of network adequacy as a component of the EQR prior to this mandatory effective date. Contractor shall develop and implement an approach for validating network adequacy until such time that CMS Protocol 4 becomes effective.

Contractor shall conduct reviews of all MCEs’ compliance with Medicaid and CHIP managed care regulations over a three-year period. Recognizing that MCEs will not have completed a full year of operations by the end of State Fiscal Year 2022, Contractor and the OHCA shall collaborate to refine the review schedule based on data availability (e.g., MCE performance data, accreditation findings), OHCA’s oversight and monitoring priorities, and CMS Protocol requirements. A preliminary schedule for completion of compliance reviews is as follows:

* Year 1 (State Fiscal Year 2022)
  + Health Information Systems
  + Quality Assessment and Performance Improvement Program
  + Coordination and Continuity of Care
  + Coverage and Authorization of Services
* Year 2 (State Fiscal Year 2023)
  + Availability of Services
  + Assurances of adequate capacity and services
  + Confidentiality
  + Provider Selection
* Year 3 (State Fiscal Year 2024)
  + Grievance and Appeals System
  + Subcontractual Relationships and Delegation
  + Practice Guidelines

d. CMS-Optional EQR Activities

Contractor shall provide the following EQR-related services, as request by the OHCA:

* Protocol 5 – Validation of Encounter Data Reported by MCEs
* Protocol 6 – Administration or Validation of Quality of Care Surveys
* Protocol 7 – Calculation of Additional Performance Measures
* Protocol 8 – Implementation of Additional Performance Improvement Projects
* Protocol 9 – Conducting Additional Focus Studies for Health Care Quality
* Protocol 10 – Assist with Quality Rating of MCEs

Contractor shall assist the OHCA with validation of encounter data, in compliance with Protocol 5 to the maximum extent feasible, during State Fiscal Year 2022.

MCE’s are required to administer member and provider surveys; Contractor shall be responsible for validation activities in accordance with nonduplication guidelines. At the OHCA’s request, Contractor shall be responsible for developing, administering and validating one additional survey each fiscal year, beginning in State Fiscal Year 2024. Contractor and the OHCA shall collaborate to define the objectives and approaches for these annual surveys.

e. Information Systems Capabilities Assessment (ISCA)

Contractor shall perform the ISCA for each MCE in accordance with Appendix A of the CMS EQR Protocols. The ISCA is a required component of the EQR for the following Protocol Activities:

* Protocol 1 - Validation of Performance Improvement Projects
* Protocol 2 - Validation of Performance Measures
* Protocol 3 - Review of Compliance with Medicaid and CHIP Managed Care Regulations
* Protocol 4 - Validation of Network Adequacy
* Protocol 5 - Validation of Encounter Data
* Protocol 7 - Calculation of Additional Performance Measures

Contractor shall be responsible for completion of the ISCA for all participating MCEs by the end of State Fiscal Year 2022.

f. Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Review

Contractor shall perform an annual evaluation of each MCE’s compliance with the EPSDT requirements as set forth in the OHCA-MCO or OHCA-DBM contract and as required by federal regulations. Contractor shall prepare an Annual EPSDT Compliance Report that presents findings of the Contractor’s evaluation of participating MCEs’ processes, practices and evidence of compliance with EPSDT requirements. The evaluation shall include but is not limited to the following:

* Appropriateness and timeliness of determinations regarding medical necessity;
* Ensuring continuation of services;
* Prior authorization and utilization review procedures;
* Screening and referring members across levels of care and types of care;
* Education and outreach activities for both members and providers, including development of specialist referral lists for primary care providers;
* Notifications for members and providers;
* Risk assessment and care management functions;
* Monitoring access to care; and
* Coordination of services with state agencies and schools.

The annual report also shall identify best practices across participating MCEs.

A draft of the Annual EPSDT Compliance Report shall be due to the OHCA by November 1st, with the final report due within 30 days of receiving the OHCA’s feedback on the draft report.

g. Utilization Review, Quality of Care Reviews, and Diagnosis-Related Group (DRG) Validation

Contractor shall provide the following services for Medicaid claims that are paid on a fee-for-service basis:

* Retrospective reviews of inpatient hospital admissions and outpatient hospital observation stays;
* Retrospective DRG validation of inpatient hospital admissions;
* Retrospective reviews to support the Payment Accuracy Measurement (PAM) and State Auditor projects; and
* Quality Education and Intervention.

Contractor shall develop and implement a comprehensive approach for performing retrospective reviews, to include the following:

* Selecting claim sample utilizing statistically sound methodology and specific criteria;
* Requesting and receiving medical records;
* Performing first-level nurse and coder reviews and second-level physician reviews;
* Issuing denial/determination letters;
* Conducting third-level reviews based on reconsideration requests; and
* Participating in Medical Education and Intervention Team (MEIT) peer review process as necessary.

The targeted number of retrospective case reviews are as follows:

* Inpatient hospital admissions: 300 per month;
* Outpatient hospital observation stays: 100 per month;
* Focus areas: 100 per month (to be defined through collaboration between Contractor and the OHCA);
* Payment Accuracy Measurement (PAM) and State Audit and Inspector (SA&I): up to 200 per year; and
* Medical Education and Intervention: up to 5-10 per year.

During the initial contract period, Contractor may elect to commence monthly reviews up to two months following the operations start date; however, the average number of monthly reviews performed in the initial contract period and first renewal period shall be equal to the monthly targets defined above.

Contractor shall develop sampling plans and create samples that comply with the following requirements:

* Between the 6th and 12th day of each month, access the OHCA Data Warehouse using Business Objects to extract sample of claims with a final issue warrant date within the past month;
* Sampling shall be based on a statistically sound methodology, to be submitted to the OHCA for review and approval annually and as changes are implemented;
* Collaborate with OHCA quarterly to develop specific criteria for sample selection; and
* Exclude Medicare claims.

Contractor shall perform medical record requests in accordance with the following requirements:

* Within 15 days of the date Contractor extracts the sample from the OHCA Data Warehouse, request hospital medical records for the monthly selected sample;
* Allow 30 calendar days for hospitals to submit the requested medical records;
* Accommodate hospital submissions of electronic, paper, fax, and secure electronic media (such as CD) medical records and documentation;
* Issue Technical Denial (TD) for cases when the facility (hospital) does not submit complete medical records within 30 calendar days from the date of the initial request. (Does not apply to Payment Accuracy Measurement (PAM) cases);
* Issue Technical Recoupment letter for cases when the facility (hospital) does not submit complete medical records within 45 calendars after the initial request;
* Hold TD cases for 12 months;
* If the medical record is received within 12 months, review the case and if the case is approved, issue Technical Denial Reversal letter to the facility (hospital);
* If the complete medical record is not received within 12 months of the TD, the case will be closed by the contractor; and
* TD cases are may be billed as a completed case when reported to OHCA.

Case reviews shall be conducted by appropriately licensed and/or certified reviewers. All cases shall be reviewed for the following:

* Medical necessity
* Quality of care
* Diagnosis-Related Group (DRG) validation (Inpatient claims only)

Inpatient and outpatient reviews shall be performed in accordance with the following requirements:

* Within 60 days of the receipt date of medical records, conduct first level nurse and coder reviews and, if findings, conduct second level physician review with determination;
* Identify medically unnecessary admissions/observation placement, lengths of stay, transfers, healthcare services, inappropriate billing, and quality of care issues;
* Utilize evidenced-based clinical screening criteria, OHCA specific, community guidelines, and/or best professional judgment based on CMS guidelines for qualifying services;
* Conduct DRG validation (inpatient claims only) to ensure the medical record documentation supports the diagnosis and procedures the physician submitted for payment and are coded correctly based on current coding guidelines;
* Issue Billing Error letter where billing is inconsistent with the level of care provided;
* Send provider notification letters to hospitals and providers within 10 days of determination and forward a copy of the letter to the OHCA;
* Conduct provider and facility tracking and trending;
* Report all trending (three (3) occurrences per quarter) providers and facilities to OHCA quarterly (admission/coding denials, coding modifications, quality concerns, billing errors, and technical denials);
* Report within 48 hours of determination if quality concern is at the level of Serious Risk or Gross and Flagrant; and
* Respond to provider inquiries about the review processes.

Contractor shall process adverse determinations and reconsiderations in accordance with the following requirements:

* Within 10 days of a finding, notify a provider in writing and offer provider an opportunity to provide additional documentation regarding the finding and request a reconsideration within 30 days;
* When a request for reconsideration is not received within 30 days, issue final upheld determination letter to provider and forward a copy to the OHCA;
* Within 45 days of receiving a reconsideration request, conduct a third level peer review of like specialty using a peer reviewer not involved with the initial determination;
* For all cases with identification of a Serious Risk or Gross and Flagrant Violation, conduct a third level peer review of like specialty (regardless of reconsideration request);
* Within 10 days of a third level review finding, issue the final determination letter to provider and forward a copy to the OHCA; and
* Compete provider tracking and trending for final DRG, medical necessity and quality of care findings.

Contractor shall conduct PAM and SA&I reviews in accordance with the following requirements:

* Receive files(s) for Payment Accuracy Measurement (PAM) project in two files: Children's Health Insurance Program (CHIP) and Title 19 (TXIX);
* Receive file for State Audit and Inspector (SA&I) reviews;
* Within 15 days of receipt of the file(s) from OHCA, send Medical Record Request (MRR) by certified mail for all PAM or SA&I cases;
* On the 16th day after the date of the MRR, call providers who have not yet submitted PAM or SA&I medical records;
* On the 20th day after the date of the MRR, notify OHCA of any requested PAM or SA& I medical records not received;
* Within 30 days of receipt of the medical record, conduct first level review and, if findings, a second level review with determination;
* For SA&I provide findings to OHCA (only);
* For PAM cases only, within five (5) days of confirmed findings, issue a written determination to the provider with a copy to OHCA. Determination letter will include instructions for providers to request reconsideration within 20 days of the date of the letter;
* (PAM only) Within 30 days of receiving a reconsideration request and additional documentation, conduct third level review with determination; and
* Within five (5) days of the third level (reconsideration) determination issue a determination letter to the provider with a copy to OHCA for any applicable PAM case.

Quality interventions and education are performed to identify, educate, and closely monitor care delivery of medical providers who have provided substandard care in SoonerCare programs. Cases may be identified by Contractor or may receive referrals from the OHCA. Contractor shall be responsible for managing up to 10 case reviews per year. Contractor shall provide the following activities related to Quality Interventions and Education:

* Identify, educate and monitor care delivery for providers who have provided substandard care;
* Coordinate and participate in general Medical Education/Intervention Team (MEIT) monthly or as requested by OHCA;
* Coordinate all correspondence, including notifications to licensure agencies, and provide copies of all correspondence to OHCA;
* Request medical records for specified dates of service and an agreed upon number of members;
* Conduct expedited and standard peer reviews in accordance with established timeframes;
* Notify provider and OHCA in writing within 10 days of initial determination;
* Conduct peer reviews using like specialty when provider requests a reconsideration;
* For all Serious Risk or Gross and Flagrant Violation, conduct a second peer review of like specialty (regardless of reconsideration request);
* Notify provider and OHCA in writing within 10 days of final determination;
* Coordinate and conduct Focused MEIT meetings that include the Contractor’s Medical Director, a peer reviewer with the same specialty, and a peer reviewer with the same geographical practice setting, staff representative and OHCA representatives;
* Develop Corrective Action Plans (CAPs); and
* If a CAP is issued, monitor and reassess provider’s progress with a peer review for a sample of members who received care subsequent to the CAP.

h. Quality Improvement/Compliance Supports

Contractor shall provide the following services to support the OHCA’s quality improvement activities and initiatives:

* + Contractor shall participate in OHCA Quality Improvement meetings, including through membership on any standing committees established by the OHCA to address clinical and administrative quality improvement;
  + Contractor shall assist OHCA in the development of the initial managed care Quality Strategy (QS), annual evaluations and updates to the quality strategy. Working in collaboration with OHCA and at the OHCA’s request, the Contractor shall develop evaluation methodologies/tools, draft narrative reports of findings, develop required components of the QS, and prepare updates required by CMS;
  + Contractor shall inventory, monitor and offer recommendations regarding all quality improvement activities, including MCO/DBM PIPs, ensuring that quality improvement activities align with the OHCA’s program objectives;
  + Contractor shall support annual Quality Forums, as requested by the OHCA. Contractor tasks include managing participant invitations/attendance lists, preparing Quality Forum topic areas and supporting materials, preparing presentations, presenting at the Forums; and facilitating Forum discussions and exercises; and
  + Contractor shall make presentations at OHCA Board meetings, regional quality meetings, executive management meetings, legislative sessions, and stakeholder meetings, as requested.

i. Assist with Readiness Reviews/Corrective Action Plans

If requested by the OHCA, Contractor shall assist the OHCA to prepare and conduct MCE readiness reviews.

As requested, Contractor’s assistance may include preparation of readiness review guides, participation in on-site reviews, preparation of findings and any follow-up activities.

If requested by the OHCA, Contractor shall assist with the development and oversight of Corrective Actions Plans.

## Data Management and Security

1. Notwithstanding the Specific Requirements of this Section, Contractor shall comply with all Data Management and Sharing Requirements Specified in Section B, Contract Terms and Conditions;
2. Contractor shall maintain a health information management system in full compliance with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), requirements set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH) in 42 USC 17931, Section 6504(a) of the Affordable Care Act and other applicable State and federal laws and regulations;
3. Contractor shall ensure that its information technology system is compliant with any future State or federal regulations within the timeframe stipulated by the regulatory body;
4. Contractor’s system shall be updatable to accommodate changes required by or resulting from CMS or OHCA policy directives and protocols;
5. Contractor’s system shall accommodate existing and new OHCA processes;
6. Hardware and software for Contractor’s information systems, and all other electronic communication must be sufficient to meet the service and reporting requirements of this RFP and acceptable to the OHCA;
7. Gainwell Technologies (formerly DXC Technology) is currently contracted to operate the OHCA Medicaid Management Information System (MMIS) and to be the System Integrator for all contractors. The OHCA MMIS currently encompasses claims processing, member eligibility and enrollment, provider contracting, member and provider files, prior authorization system, data warehouse, etc. Contractor shall be required to coordinate with the System Integrator to complete the scope of work for this contract;
8. Contractor’s system shall be compatible with the OHCA MMIS, to include mapping data fields so that transfer of data from the OHCA to Contractor and vice versa is completed within “real time” or within two (2) calendar days. Contractor is responsible for ensuring its data is up-to-date and shall make changes to their system as needed to accommodate transfer of data;
9. If Contractor chooses to directly access the OHCA’s MMIS, Contractor shall comply with all OHCA access, hardware, and software requirements;
10. If required in the future by the OHCA, Contractor shall collaborate with the agency to use or integrate with any care/medical management platform that the OHCA implements;
11. Contractor shall not require any changes or modifications to the OHCA’s MMIS;
12. Contractor shall allow the OHCA to view Contractor’s system, including all attachments and medical records associated with OHCA contract only;
13. Contractor shall accept attachments from the OHCA to add to Contractor’s system as necessary;
14. Contractor shall transfer supporting documentation to the OHCA document management system on a mutually agreed upon schedule;
15. If Contractor chooses to use electronic file transfer, Contractor shall comply with the OHCA electronic file transfer specifications; and
16. Contractor shall enable designated OHCA staff, with the appropriate permissions and security/confidentiality safeguards, to access medical records, findings and all other utilization review data within Contractor’s system. Contractor shall ensure that access to the system is available for use from 7:00 a.m. to 9:00 p.m., CT Monday through Friday, on Saturdays (except those following Thanksgiving, Christmas and New Year’s Day) between 8:00 a.m. to 12:00 Noon, CT, or, during overtime hours, as requested by the OHCA.

## Reporting

Contractor’s reporting responsibilities include, but are not limited to, the following:

1. Project Plan: Contractor shall develop and maintain a Project Plan throughout the course of the engagement that details all EQRO and QIO implementation and operational activities. The Project Plan shall address all project activities, including completion dates, dependencies/risks and status of each project task/deliverable. The Project Plan shall be reviewed with the OHCA on a weekly basis; subject to OHCA approval, the Project Plan may be reviewed with the OHCA less frequently post-implementation. Contractor shall furnish the first report one week after the Contract is executed.
2. Monthly Progress Reports: As a supplement to the Project Plan, Contractor shall submit a monthly progress report that summarizes all project activities, including performance metrics related to utilization review and intervention and education activities, such as letters, pending medical record requests, completed reviews, and trends.
3. Quarterly Progress Reports: Contractor shall submit a quarterly progress report that summarizes the status of all project activities.
4. Quarterly QIO meeting: Contractor shall prepare and submit meeting data and materials one (1) week prior to date of meeting and submit minutes within three (3) days of each meeting.
5. Final PAM Report: Contractor shall submit the final PAM Report upon completing all reviews and according to specified timeframes.
6. MEIT Meeting Case Log and Minutes: Contractor shall submit Case Log one (1) day prior to meeting and meeting minutes within three (3) days of each MEIT meeting.
7. Gross and Flagrant and Serious Risk Violation Reporting: Within 48 hours of a determination of a quality concern at the level of Serious Risk or Gross and Flagrant Violation, notify OHCA’s Chief Medical Officer (CMO) in writing.
8. Report to OHCA any security incident immediately upon discovery, (not to exceed one hour) of knowledge of the incident, as defined in the Security Rule, with respect to PHI as required by 45 C.F.R. § 164.400 et seq.
9. Draft Annual EQR Report: Contractor shall submit a draft Annual EQR Report to the OHCA for review and approval by February 28th of each year, incorporating all EQR activities and findings completed during the previous State Fiscal Year.
10. Final Annual EQR Report: Contractor shall submit the Final Annual EQR Report to the OHCA, for submission to CMS, at least seven (7) days prior to the CMS due date.
11. Final Annual EPSDT Compliance Report: Contractor shall submit the Final Report within 30 days of receiving the OHCA’s comments for the draft report.
12. Ad hoc or Special Reports: Contractor shall submit additional reports as requested by the OHCA.
13. Contractor shall furnish operational data monthly through reports and postings to an electronic dashboard, with the content of the data to be specified by the OHCA.

# A.6 Summary of Project Activities and Milestones

The table below provides a preliminary summary of project activities and milestones. (*Note: blue and green shading denotes distinct review periods.)*

