



AGENCY SOLICITATION SPECIFICATIONS

TITLE: QLV27007063 RIteSmiles 4-ALL Medicaid Managed Care Dental Services

Section A: Background

1. General Information on the RIte Smiles 4-ALL Medicaid Managed Care Dental Procurement

1.1. Rhode Island Executive Office of Health and Human Services (EOHHS)

The Rhode Island Department of Administration's Division of Purchases (RIDOP), on behalf of the Rhode Island Executive Office of Health and Human Services (EOHHS), is soliciting proposals from qualified Bidders to provide Medicaid Managed Care Dental Services to Rhode Island Medicaid beneficiaries for the RIte Smiles 4-All Program.

EOHHS serves as "the principal agency of the executive branch of state government" (RI Gen. Laws § 42-7.2-2¹) responsible for managing the Departments of: Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

Rhode Island EOHHS is a single state agency (SSA) and is a primary source of health coverage for approximately one-third of the State's population, serving more than 400,000 individuals annually². In SFY 2024, Medicaid expenditure totaled approximately \$4.3 billion, representing one of the largest components of the State budget. The program serves a diverse population, including children, families, adults with disabilities, elders, and Affordable Care Act (ACA) expansion adults, with the majority of beneficiaries enrolled in managed care. Medicaid expenditures are highly concentrated among high-need populations, with a small proportion of beneficiaries accounting for a substantial share of total spending, reflecting the clinical complexity of the population and the importance of effective managed care delivery. Approximately eighty-eight (88%) of individuals receiving full Medicaid benefits are enrolled in managed care.

EOHHS is seeking proposals from qualified Bidders to serve as Managed Care Organizations (MCOs) for the RIte Smiles 4-All Program, with a primary site of business operations in Rhode Island. Awarded and contracted MCOs will administer all daily functions related to the delivery of covered dental services for enrolled Medicaid beneficiaries as described herein.

This Solicitation is to procure statewide services under a capitated risk-bearing Contract. The RIte Smiles 4-All Program is a risk-bearing dental service delivery system. MCOs will be responsible for

¹ RI Gen. Laws § 42-7.2-2 - webserver.rilegislature.gov/Statutes/TITLE42/42-7.2/42-7.2-2.htm

² For up-to-date information on population and expenditures, please visit: <https://eohhs.ri.gov/initiatives/medicaid-initiatives/medicaid-data-dashboard>

providing Medicaid covered dental services to enrollees in return for a monthly per member, per month (PMPM) capitation payment. Awarded Bidder's are responsible for ensuring adequate risk-based capital and capital reserve levels required under rules and regulations of the Rhode Island Office of Health Insurance Commissioner (OHIC) and other rules and regulations regarding fiscal solvency.

EOHHS is seeking proposals from qualified and competent MCOs to manage the delivery of the RItE Smiles 4-All Program, as detailed in Appendix A, Model Contract.

1.2. Purpose of this Solicitation

The purpose of this solicitation is to obtain competitive proposals from qualified Bidders to provide high-quality dental services statewide to Medicaid beneficiaries in the RItE Smiles 4-ALL Program, utilizing the most cost-effective manner, and in accordance with the terms and conditions set forth herein.

EOHHS will oversee the RItE Smiles 4-ALL Program, including the overall program design. Federal requirements regarding managed care services are described in 42 CFR Part 438³ and other applicable State and Federal rules and regulations regarding the Medicaid Managed Care Program⁴. The RItE Smiles 4-ALL Program is operated under the authority of a Section 1115 Waiver. EOHHS may pursue a change in federal authority or additional federal authorities at any time for the RItE Smiles 4-ALL Program.

EOHHS is seeking to partner with MCOs that will build upon the success of the current program and further improve the dental service delivery and quality of dental services that beneficiaries receive in the managed care delivery system. This Solicitation represents an exceptional opportunity for an MCO to become a partner to EOHHS, working together to improve access to Medicaid dental services, and improve the overall population health and health outcomes of Rhode Island's diverse Medicaid beneficiaries.

EOHHS welcomes qualified new Bidders with the capabilities and expertise to provide high-quality, reliable, and cost-effective dental services to all eligible children and adults under this Solicitation. EOHHS is seeking innovative, progressive, and proactive proposals that demonstrate a commitment to and expertise in priority areas such as preventive care delivery, the promotion of non-invasive dentistry, payment reform, and leveraging technology-based solutions to reduce redundancy and administrative burden. These solutions may include the use of emerging technologies, such as artificial intelligence (AI) and advanced data analytics for sophisticated population health data analysis, enhance Member satisfaction, enforce Program Integrity safeguards, promote better health outcomes for vulnerable populations and enhance provider participation with the delivery of covered dental services through an efficient Medicaid managed care program.

1. Improve access and utilization of dental care services for Medicaid Members.
2. Improve oral health outcomes across all Member population groups.
3. Prioritize strategies that ensure improved outcomes for adult Members with I/DD.
4. Reduce disparities in utilization of oral health care services.
5. Streamline administrative processes.

³ 42 CFR Part 438 - <https://www.ecfr.gov/current/title-42/part-438>

⁴ <https://rules.sos.ri.gov/Organizations/Title/210>

6. Implement innovative solutions for Care Coordination, Case Management, Care Delivery and Payment Models.

7. Lower costs associated with the delivery of oral health care services.

EOHHS shall establish an actuarially sound risk-adjusted capitation rate to be paid to the awarded Bidders, in accordance with all applicable rules and regulations of the Center for Medicare and Medicaid Services (CMS) pursuant to 42 CFR § 438.4⁵. The rates shall not be subject to negotiation or dispute resolution. The rate is intended to cover all benefits and management services outlined in this solicitation. Each Bidder will be paid based on the distribution of Members they have in each rate cell. Capitation rates are prepared annually by EOHHS' actuaries based on the rating period.

EOHHS' actuaries have prepared State Fiscal Year 2027 RItE Smiles 4-All Illustrative Capitation Rates July 1, 2026 through June 30, 2027, dated July 30, 2026, which have been included with this solicitation in Appendix C.

There is no cost proposal associated with this Solicitation since the capitation rates are set by EOHHS' actuaries. Responses will be evaluated based on the Bidder's technical qualifications, including the submission of a business and technical proposal that clearly demonstrates the Bidder's capability to meet all requirements to achieve EOHHS's priorities, goals, terms and conditions outlined in the Solicitation, which is inclusive of all program requirements contained in Appendices.

1.3. Contract Award Information

EOHHS anticipates selecting up to three (3) qualified Bidders scoring 85 or greater during the evaluation process. EOHHS may issue an award to one (1) qualified Bidder if no other Bidders meet the passing technical score of eighty-five (85) points as required in Section D. The State retains the right to terminate this procurement process at any time should a competitive procurement process fail to occur during this Solicitation process. Should no response be found satisfactory, the State reserves the right to make no award, cancel this solicitation, and restart the procurement process.

The initial base contract period will be for three (3) years, from July 1, 2027, until June 30, 2030. Contracts may be renewed up to three (3) additional twelve (12) month periods based on Bidder's performance and the availability of funds.

The State reserves the right to initiate a new procurement during the renewal period or prior to the end of the third (3rd) year of the initial base contract period. EOHHS reserves the right to amend the Contract to include or remove new populations, services, programs, or administrative functions of the Bidder at any time.

Only successful Bidders to this solicitation will be eligible to provide covered dental services to eligible populations. To serve these populations, a Bidder must be awarded under this Solicitation and complete contract negotiations and the Readiness Review requirements outlined in Appendix A, Model Contract, Addendum F, "Agency Special Requirements", pursuant to 42 CFR § 438.66⁶.

⁵ 42 CFR § 438.4 - <https://www.ecfr.gov/current/title-42/section-438.4>

⁶ 42 CFR § 438.66 - <https://www.ecfr.gov/current/title-42/section-438.66>

1.4. Bidder Eligibility, Minimum Qualifications and Attributes

EOHHS welcomes qualified Bidders, including new market entrants, with the capabilities to provide high-quality and cost-effective dental services to Medicaid eligible populations in Rhode Island that meet the eligibility, minimum qualifications and organizational attributes required of Bidders.

1.4.1 Eligibility

Private organizations, defined as non-state entities that are either nonprofit, proprietary corporations, or partnerships that have a Rhode Island location or a proposed Rhode Island location for its central business operations established within three (3) months of the resulting contract are eligible to submit proposals in response to this solicitation.

Individuals who are not duly formed business entities are ineligible to participate in this procurement.

1.4.2 Mandatory Qualifications of Bidders

Bidders must pass the following criteria by providing an attestation and supporting documentation for each of the seven (7) required qualifications:

1. Meet the federal definition of a managed care organization (MCO), as defined in 42. CFR § 438.2⁷;
2. Have a minimum of three (3) consecutive years of experience managing an array of medical, and or dental services covered by Medicaid and/or Medicare and serving a minimum combined total of fifty thousand (50,000) Medicaid, Medicare, or Medicaid-like⁸ members in one (1) or more U.S. states or territories;
3. Not an excluded individual or entity, as described in 42 CFR § 438.808(b)⁹;
4. Have the capacity and willingness to perform all functions in this solicitation, including the terms stipulated in Appendix A Model Contract, consistent with Medicaid managed care requirements defined in 42 CFR § 438¹⁰;
5. Have its principal place of business located within the United States;
6. Be currently accredited by a nationally recognized agency such as National Committee for Quality Assurance (NCQA) and/or Utilization Review Accreditation Commission (URAC) as defined in 42 CFR § 438.224¹¹; and,
7. The Bidder, its corporate parent, or subsidiary of its corporate parent performing managed care services in another state has not been sanctioned, as defined in 42 CFR § 438.702¹², by a state or Federal government within the last ten (10) years.

⁷ 42 CFR § 438.2 - <https://www.ecfr.gov/current/title-42/section-438.2>

⁸ Medicaid-like populations can broadly be defined as populations that have the following attributes: 1) Have low-income; 2) Must meet eligibility criteria that is determined by attributes or characteristics, such as family size, disability status, etc.; 3) Have complex health care needs or multiple comorbidities; or, 4) Includes vulnerable or underserved populations. A Bidder who is including Medicaid-like populations to qualify for Minimum Bidder Qualifications must justify how their covered lives meets the definitions as defined in this solicitation.

⁹ 42 CFR § 438.808(b) - <https://www.ecfr.gov/current/title-42/section-438.808>

¹⁰ 42 CFR § 438 - <https://www.ecfr.gov/current/title-42/part-438>

¹¹ 42 CFR § 438.224 - <https://www.ecfr.gov/current/title-42/section-438.224>

¹² 42 CFR § 438.702 - <https://www.ecfr.gov/current/title-42/section-438.702>

1.4.3 Organizational Attributes of Bidders

Qualified Bidders should have a proven track-record and possess the following attributes in the following areas to be successful in managing the RItE Smiles 4-ALL Program:

- Financial management, stability and solvency to manage a risk-bearing contract, including full or partial risk Medicaid managed care dental contracts;
- Ability to develop a sufficient provider network that meets the unique health care needs of the whole Medicaid population, including services for vulnerable populations;
- Organizational capacity to manage the proposed services inclusive of administrative, managerial and clinical staff to manage the unique care management needs of the Medicaid population;
- Robust information systems that can manage and handle the complex Member data to oversee and administer the program inclusive of encounter data requirements under 42 CFR § 438.242¹³, as well as new and emerging data types such as closed-loop referrals; and
- Must be knowledgeable of applicable laws and regulations, including those related to healthcare, privacy, security, and program integrity.

1.5. Serving All Medicaid Eligible Populations and Geographic Coverage

By submitting a proposal to this solicitation, the Bidder is unequivocally agreeing to serve all Medicaid populations statewide, inclusive of contracting with network providers in Border Communities pursuant to 210-RICR-20-00-3¹⁴, under the terms and conditions of Appendix A, Model Contract. The awarded Bidders are strictly prohibited from bidding on certain populations (i.e., the practice known as ‘cherry-picking’), including requesting to provide services to specific populations or only risk-adverse populations.

Awarded Bidders must be able to serve all populations equally and no one (1) awarded Bidder shall have exclusive rights to serve exclusive populations. The State reserves the right at its sole discretion to award a Bidder a defined population if they are most qualified based on previous experience or expertise in serving a particular population under this Solicitation. This modification is at the sole discretion of the State.

1.6. Multiple Proposals by Bidders

The submission of multiple proposals by an MCO in response to this solicitation is prohibited.

1.7. Ownership of Information

RIDOP, EOHHS, CMS and the State of Rhode Island, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by a Bidder under any contract resulting from this solicitation.

An awarded Bidder agrees to grant on its own behalf and on behalf of its agents, employees, representatives, assignees, and subcontractors to EOHHS, RIDOP, CMS and the State of Rhode Island,

¹³ 42 CFR § 438.242 - <https://www.ecfr.gov/current/title-42/section-438.242>

¹⁴ <https://rules.sos.ri.gov/Regulations/part/210-20-00-3>

and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Bidder.

Excluded from the foregoing provisions in this Section, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by the winning Bidder independent of the Contract. The Bidder and any eventual Bidder is and shall remain the owner of all rights, title, and interest in and to the Proprietary Tools is granted or otherwise implied. Any right that the State of Rhode Island may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

1.8. Reservation of Rights

The State may make such investigations necessary to determine the ability and commitment of the Bidder to adhere to the requirements specified within this solicitation and its qualifications contained within the proposal. The Bidder shall furnish all such information and data for this purpose as may be requested by the State.

The State reserves the right to inspect the Bidder's physical facilities prior to an award to satisfy questions regarding the Bidder's ability to fulfill the requirements of the Contract. The State reserves the absolute right to reject any qualification if the evidence submitted by, or investigations of, such Bidder fail to satisfy that the Bidder is properly qualified to carry out the obligations of the Contract and complete the work or furnish the required items.

The State reserves the right to reject any and all qualifications, to negotiate with the best proposed Bidder to address issues other than those described in the Bidder's proposal or not make any award if it is determined to be in the best interest of the State.

The State reserves the right to request additional information or clarification of a Bidder's qualifications or proposals. Lack of such cooperation or failure to provide the information in the manner required may result in the disqualification of the Bidder's proposals and subsequent award.

1.9. Restrictions on Communication with EOHHS Staff

From the issue date of this solicitation until Bidders are selected and a purchase order has been issued, Bidder's and/or their representatives are not allowed to communicate with any EOHHS staff and/or EOHHS Bidders regarding this procurement.

For violation of this provision, the State reserves the right to reject any Bidder's proposal and cancel the solicitation.

1.10. Accuracy of Statistical Data

All statistical information provided by EOHHS in relation to this solicitation represents the best and most accurate information available to EOHHS from records at the time of this solicitation's preparation. EOHHS, however, disclaims any responsibility for the inaccuracy of such data. Should any element of such data later be discovered to be inaccurate, such inaccuracy shall not constitute a basis for a Contract rejection by any Bidder or awarded Bidder. Neither shall such inaccuracy constitute a basis for renegotiation of any payment rate after Contract award.

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2. Overview of the Rhode Island Medicaid Program

The Medical Assistance Program, or Medicaid, is a health care entitlement program for the State's low-income population that is jointly funded by the Federal Government and the State of Rhode Island. Medicaid was established in 1965 as Title XIX of the U.S. Social Security Act. In addition to State oversight, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS") monitors the State's Medical Assistance program activities.

Medicaid is a primary source of health coverage in Rhode Island, serving approximately twenty-nine to thirty-three percent (29-33%) of the State's population. In State Fiscal Year (SFY) 2024, Rhode Island Medicaid provided coverage to approximately 408,000 individuals at some point during the year, with an average monthly enrollment of approximately 348,000 beneficiaries. Total Medicaid expenditures were approximately \$4.3 billion, with a State share of approximately \$1.7 billion, representing one of the largest components of the State's overall budget.

The Medicaid population is diverse and includes Children and Families, Adults with Disabilities, Elders, Children with Special Health Care Needs, and the Affordable Care Act Expansion population. In SFY 2024, Children and Families represented the largest share of enrollment (approximately fifty-two percent (52%)), followed by the Expansion population (twenty-eight percent (28%)), Adults with Disabilities (eight percent (8%)), Elders (eight percent (8%)), and Children with Special Health Care Needs (four percent (4%)). Most Medicaid beneficiaries (approximately eighty-eight percent (88%)) were enrolled in managed care.

Per member per month (PMPM) medical costs averaged approximately \$921 in SFY 2024, with significantly higher costs for Elders and Adults with Disabilities compared to other populations. These trends reflect ongoing growth in healthcare costs and the increasing clinical complexity of high-need populations served by the Medicaid program.

2.1. Expenditures for Each Major Population Group (SFY 2024)

2.1.1 Adults with Disabilities:

Represent approximately eight percent (8%) of the Medicaid population (28,321 individuals) and account for twenty-five percent (25%) of Medicaid expenditures (\$976.0 million), with an average per member per month (PMPM) cost of \$2,872. The primary drivers of expenditures for this population are intellectual and developmental disability (I/DD) services and long-term services and supports, followed by hospital and professional services.

2.1.2 Elders:

Represent approximately eight percent (8%) of the Medicaid population (28,055 individuals) and account for twenty-two percent (22%) of Medicaid expenditures (\$826.4 million). Elders have an average PMPM cost of \$2,455, among the highest of all eligibility groups. Nursing facility services account for approximately forty-five percent (45%) of expenditures for this population.

2.1.3 Children and Families:

Represent approximately fifty percent (52%) of total Medicaid enrollment (182,339 individuals), including low-income children, parents, and pregnant women who meet income eligibility requirements. This population accounts for twenty-five percent (25%) of total Medicaid expenditures (\$965.1 million) and has an average PMPM cost of \$441, the lowest among major

eligibility groups. Hospital and professional services account for the majority of expenditures for this population.

2.1.4 Children with Special Health Care Needs (CSHCN):

Represent a relatively small population, encompassing four percent (4%) of Medicaid recipients (12,176 individuals), but account for seven percent (7%) of Medicaid expenditures (\$278.2 million). The average PMPM cost for this population is \$1,904, with professional services comprising the largest share of expenditures.

2.1.5 Expansion Population:

Represents approximately twenty-eight percent (28%) of the Medicaid population (96,960 individuals) and accounts for twenty-one percent (21%) of total Medicaid expenditures (\$818.2 million). Hospital services are the largest driver of expenditures for this population, followed by professional services.

2.2. Additional Medicaid Expenditures

2.2.1 Major Service Categories

Hospital and nursing facility services represent a significant share of total Medicaid expenditures, with nursing facility services accounting for approximately forty-three percent (43%) of elder expenditures and I/DD and long-term services and supports representing a substantial share of spending for adults with disabilities. Overall, institutional and acute care services remain key cost drivers within the Medicaid program.

2.2.2 High-Cost Utilizers

Medicaid expenditures are highly concentrated among a small subset of beneficiaries. A small proportion of enrollees with complex medical and long-term care needs account for a disproportionate share of total Medicaid spending, particularly among adults with disabilities, elders requiring institutional care, and high-cost expansion adults with significant acute or behavioral health needs.

2.2.3 Medicaid Eligibility Overview

Traditional RI Medicaid beneficiaries (non-Medicare, non-dual) are generally enrolled in Managed Care Plans. EOHHS maintains all current populations enrolled in managed care as described in the eligibility group summaries below. EOHHS reserves the right to amend eligibility, including adding or removing eligibility groups, under this solicitation.

2.3. RIteCare Eligibility Groups

2.3.1 Families

This group consists of persons categorically eligible for Medicaid based on RI Works or RI Works-related status or based on families with a minor child or children under age eighteen (18) with income specified by the State.

2.3.2 Children Under Age Nineteen (19) with Income up to 261% of FPL

This aid category consists of Rhode Island residents under nineteen (19) years of age whose family income is at or below 261% of the Federal Poverty Level (FPL). As outlined in 210-RICR-30-00-

1 (MACC group eligibility), this coverage group includes all children and young adults under age nineteen (19) with income up to 261% of the FPL, regardless of citizenship or immigration status.

2.3.3 Pregnant Individuals with Income up to 253% of FPL

Rhode Island Medicaid covers pregnant individuals who are state residents and whose household income does not exceed 253% of the Federal Poverty Level (FPL). Coverage under this group includes the full scope of Medicaid benefits for the duration of the pregnancy and continues for twelve (12) months postpartum. Pregnant applicants who meet Medicaid citizenship and immigration requirements will be enrolled in Medicaid; individuals with income above certain thresholds may be enrolled in CHIP with eligibility based on the unborn child's status. Retroactive coverage for up to ninety (90) days prior to the application may also be available.

2.3.4 Extended Family Planning (EFP) Group

This group consists of individuals who meet the following criteria: have qualified for RItE Care; were pregnant and are now twelve (12) months postpartum or twelve (12) months post loss of pregnancy; and are subject to losing Medicaid eligibility. The group is eligible to receive a schedule of family planning-related benefits for up to twenty-four (24) months. Individuals who qualify for this category remain with the same Health Plan that provided coverage during pregnancy

2.3.5 Children with Special Health Care Needs.

This group includes:

- Blind/disabled individuals up to age twenty-one (21) who are eligible for Medicaid based on SSI;
- Individuals up to age twenty-one (21) receiving subsidized adoption assistance;
- Children in substitute care ("foster care") (enrollment in RItE Care for these children will be based on EOHHS determination of managed care eligibility) or eligible based on participation in a DCFY kinship or guardian program (whether in a home-based, residential, or institutional setting, as applicable);
- Adults between the ages of twenty-one (21) and twenty-six (26) who were previously active with the Department of Youth and Family Services (DCYF) and do not have other comprehensive coverage; and
- Youth who opt to remain in the care of DCYF up to age twenty-one (21) if they entered foster care on or after their sixteenth (16) birthday and did not achieve permanency (including but not limited to adoption and reunification etc.) and were set to age out of foster care; and
- Individuals up to age twenty-one (21) that are Dually Eligible for both Medicaid and Medicare.

2.3.6 Uninsured Children with Income Above the Medicaid Limit.

Rhode Island does not include a distinct Medicaid category for uninsured children up to age eighteen (18) whose household income is above the Medicaid Affordable Care Coverage (MACC) threshold. Under current rules, children up to age nineteen (19) whose family income is at or below 261% of the Federal Poverty Level (FPL) are eligible for Medicaid (RItE Care), including uninsured children regardless of citizenship status. Children with income above the Medicaid

eligibility limits may be eligible for coverage under the Children's Health Insurance Program (CHIP), which covers uninsured children whose family income exceeds Medicaid limits, subject to CHIP eligibility criteria.

2.3.7 Rhody Health Partners Eligibility Group

- a. Individuals aged twenty-one (21) and older who are categorically eligible for Medicaid.
- b. Individuals who meet the federal/state eligibility requirements without needing to "spend down" as medically needy. Individuals who must spend down to qualify are not considered categorically eligible. Under Rhode Island Medicaid (administered by EOHHS), categorical eligibility is achieved when an applicant qualifies based on:
 - Income
 - Resources (if required)
 - A defined characteristic (e.g., age, disability, family role)
 - Level of need (for some long-term care services)
- c. Not covered by other third-party health insurance (including Medicare); and
- d. Residents of Rhode Island.

2.3.8 Affordable Care Act (Adult Expansion) Eligibility Group:

- a. Adults between the ages of nineteen (19) and sixty-four (64), who:
 - Are at or below the States specified FPL based on household income (using the application of a modified adjusted gross income);
 - Are not pregnant;
 - Otherwise, do not qualify for Medicaid;
 - Are not eligible for or enrolled in Medicare;
 - Are women in the ACA Expansion Group who become Pregnant
- b. Women in the ACA Expansion group who become pregnant while enrolled are guaranteed eligibility for comprehensive services through two (2) months postpartum or post loss of pregnancy and then are eligible for an Extended Family Planning benefit for up to an additional twenty-four (24) months.

2.3.9 Excluded Populations Under This Solicitation

The following Medicaid populations are excluded from enrollment in RItE Smiles 4-ALL under this solicitation, and will instead be enrolled in the Fee-for-Service program:

- a. Recipients receiving services in an Intermediate Care Facility for Intellectual or Developmental Disabilities (ICF/IDD).
- b. Partial Dual Eligible individuals that qualify for a Medicare Savings Program but do not receive full Medicaid medical benefits.
- c. Full-Benefit Dual Eligibles (FBDEs) who do not select a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) for the coverage of their Medicare benefits.
- d. Those incarcerated greater than five (5) days.
- e. PACE Program Enrollees.

- f. Enrollees in RItShare.
- g. Enrollees in Medicaid Fee-for-Service

The following Medicaid beneficiaries are not enrolled in the RIt Smiles 4-ALL managed dental program and instead receive dental benefits through the Medicaid fee-for-service system:

- a. Children and adults with access to third-party dental coverage.
- b. Children and adults residing in nursing facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).
- c. Children and adults residing outside the State of Rhode Island.

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3. Evolution of Managed Care in Rhode Island

When Medicaid began in the mid-1960s, the RI Medicaid program was modeled as a traditional indemnity fee-for-service (“FFS”) health insurance program. Throughout the years, the State has progressively transitioned from a payer to an active purchaser of care. Central to this progression has been a focus upon improved access and quality, along with cost management. Contracting with managed care organizations (“Health Plans”) provides a structure for measuring and enforcing performance standards. Both of Rhode Island’s medical Medicaid managed care organizations were rated four point five (4.5) out of five (5) by the National Committee for Quality Assurance (“NCQA”).

The State’s first Medicaid managed care program, RItE Care, began in 1994, enrolling over 70,000 low-income children and families. A key contractual element was the “mainstreaming” provision, requiring Health Plans to ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RItE Care enrollees without discrimination. Children in Substitute Care Arrangements were voluntarily enrolled in RItE Care in December 2000 and Children with Special Health Care Needs (“CSHCN”) were voluntarily enrolled in RItE Care in 2003. Enrollment in managed care for CSHCN became mandatory in 2008.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for persons with disabilities. In the fall of 2009, all Medicaid eligible “aged, blind and disabled” (“ABD”) adults without third-party coverage (“TPL”) who resided in the community were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State’s FFS Primary Care Case Management (“PCCM”) program, Connect Care Choice (“CCC”). Currently, there are approximately 15,000 enrolled in the Rhody Health Partners Program. This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the State has expanded the program requirements and covered benefits contained in the Health Plans contracts, while also increasing the Health Plan performance requirements for managing the health care needs of complex populations.

The RItE Share Program is the State’s Premium Assistance Program under Medicaid where the State purchases employer-sponsored health insurance for RItE Care-eligible, low-income, working individuals and their families who are eligible for employer-sponsored insurance but could not otherwise afford it. The RItE Share Program reduces the amount of State Medicaid funds that would otherwise be necessary to serve these State residents if the RItE Share Program did not exist.

In SFY 2023, approximately eighty-eight percent (88%) of Medicaid beneficiaries were enrolled in managed care, and managed care accounted for roughly fifty-eight to sixty percent (≈58–60%) of total Medicaid expenditures. The Rhode Island Medicaid Managed Care Plan has consistently been ranked among the best in the nation. Please reference the Rhode Island Annual Medicaid Expenditure Report for further details regarding Medicaid managed care expenditures.

Currently, there are four (4) health plans participating in the Medicaid managed care program. Three (3) medical Medicaid managed care programs: (1) Neighborhood Health Plan of Rhode Island (“NHPRI”); (2) UnitedHealthcare of New England (“UHC”); and (3) Tufts Health Public Plans of Rhode Island. (“THPP”) The total enrollment in all medical health plans. The fourth participating health plan and only Medicaid dental managed care plan for the current RItE Smiles program is (4) UnitedHealthcare Dental (“UHC-Dental”). Current MCO enrollment totals can be found in a subsequent Table.

4. Managed Care Delivery System Overview

4.1. Current Medical Managed Care Organization Participation

EOHHS contracts with three (3) MCOs to administer medical care for Medicaid Members. The three (3) MCOs are:

- Neighborhood Health Plan of Rhode Island (NHPRI);
- Tufts Health Public Plans of Rhode Island (THPP); and,
- UnitedHealthcare of New England (UHC).

4.2. Children in Substitute Care

Children in substitute care arrangements (i.e., foster homes, group homes or in other DCYF designated/approved living arrangements) are currently enrolled in a single contracted MCO, NHPRI. A future medical solicitation will require all Bidders to provide coverage for children in substitute care. Likewise, NHPRI is the only MCO that participates in the Integrated Care Initiative, Rhode Island's Financial Alignment Demonstration program.

4.3. Current Dental Managed Care Organization Participation

EOHHS contracts with one (1) dental MCO to administer dental services for Medicaid children and young adults. The current MCO Contractor is UnitedHealthcare of New England (UHC). Current RItE Smiles beneficiaries are the Rhode Island Medicaid population born on or after May 1, 2000, who reside in households with income less than 250% of the Federal Poverty Level ("FPL") To date, the specific population groups enrolled in RItE Smiles have consisted of children, children with special healthcare needs and the Medicaid Expansion young adults.

4.4. Current Health Plan Distribution of Medicaid Managed Care Members

The Table below shows the distribution of Medicaid medical and dental managed care enrollment by eligibility category and by Medicaid managed care plan as of April 2026. Although PACE program enrollees are part of managed care programming in RI Medicaid, the enrollment total for April 2026 has been excluded from the table due to PACE program enrollee exclusion from RItE Smiles.

RI Medicaid Managed Care Enrollment By Plan April 2026	
Managed Care Health Plan/Payer	Total
Neighborhood Health Plan of RI	168,303
Tufts	13,776
United Healthcare	69,924
Current Medical Managed Care Total *PACE Enrollees are excluded.	252,003
Current (Legacy) RItE Smiles (Dental)	127,947

4.5. RI Medicaid Managed Care Enrollment Data as of April 30, 2026

The Table below shows the distribution of RI Medicaid managed care medical and dental enrollment by eligibility category as of April 2026

RI Medicaid Managed Care Enrollment as of April 30, 2026		
Medical Assistance Eligibility Group	Program	Total
Core	RIte Care Excluding: CSHCNs	151,384
Children with Special Health Care Needs (CSHCNs)	RIte Care: CSHCNs excluding Children in Substitute Care	9,193
Children in Substitute Care	RIte Care: CSHCNs including only those in Substitute Care	1,802
Aged, Blind and Disabled	Rhody Health Partners	52,836
Medicaid Expansion	Affordable Care Act	75,108
Total RI Medicaid Enrollment		290,585

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5. RItE Smiles and RItE Smiles 4-ALL Programs

5.1. History of RItE Smiles Program

RItE Smiles is a carve-out Medicaid managed care model established by the RI EOHHS, under the authority of a Centers for Medicare and Medicaid Services (CMS), Section 1115 Demonstration Waiver. Under this administrative model, gains have been made to increase access to care for RI's most vulnerable children.

In the fall of 1998, DHS (which was then the Medicaid SSA) established the Medicaid Dental Advisory Committee ("MDAC") with the purpose of developing recommendations for improving access to dental services for individuals covered by Rhode Island Medicaid, including children and families enrolled in RItE Care and uninsured working families. The committee included representatives of the Rhode Island Dental Association, Samuels Dental Center at Rhode Island Hospital, St. Joseph Hospital Dental Program, the Rhode Island Health Center Association, Rhode Island KIDS COUNT, the Rhode Island Foundation, the Rhode Island Dental Hygienist Association, Crossroads RI, the Rhode Island HMO Association, two (2) Rhode Island-based dental benefit managers, private practice dentists, other State agencies and consumer advocacy groups.

In 1999, MDAC recommended that EOHHS develop purchasing specifications for a Dental Benefit Manager ("DBM"). The DBM program was expected to be implemented as an alternative to the FFS dental system for Medicaid enrolled children. After being awarded Robert Wood Johnson funding in 2002, EOHHS began the planning process to implement the state's first managed care dental model. Several strategic approaches were implemented that created additional dental provider capacity in the state. DHS developed a Request for Proposals ("RFP") soliciting a qualified organization to serve as the DBM for Rhode Island Medicaid recipients through a program called RItE Smiles. The State issued a Bid Specification Document to procure the services of a DBM in December 2005.

The RItE Smiles program was implemented on September 1, 2006, as the State's first children's Medicaid managed care dental program. RItE Smiles is designed to improve access to quality, timely and appropriate dental services by: (1) increasing the number of dental providers participating in the Medicaid program, (2) promoting preventive and primary dental treatment, and (3) reducing the need for high-cost restorative and emergency dental procedures for children. Due to its unique program features, the RItE Smiles program continues to receive national attention.

National Medicaid dental utilization rates for children have been largely stagnant in the high-40% to low-50% range post-COVID, with Rhode Island typically near the national average. In FFY 2023, approximately forty-seven percent (47%) of Medicaid-enrolled children under age twenty-one (21) received at least one dental service, placing Rhode Island in the middle tier of states for pediatric Medicaid dental utilization. By way of comparison, sixty-five percent (65%) of privately insured children in the U.S. received at least one dental service. EOHHS anticipates further strategies aimed at increasing the utilization of preventive dental care services for the RItE Smiles population.

As of April 30, 2026, there were 127,947 children and young adults born on or after May 1, 2000, enrolled in the current RItE Smiles Program. The eligibility groups consist of the following:

- Uninsured Children and/or Young Adults Born on or After May 1, 2000, under 250 Percent of the Federal Poverty Level ("FPL"): This aid category consists of children born on or after May 1, 2000, living in families whose income is under 250 percent of the FPL.

- Children in Substitute Care: This aid category includes children in foster care born on or after May 1, 2000, who are currently enrolled in RItE Care on a voluntary basis or are in Medicaid fee-for-service (“FFS”). These children receive the same benefits as any other children (e.g., RI-WORKS/TANF). The medical benefit of Children in Substitute care is only administered by NHPRI.
- Children with Special Health Care Needs: This group includes children on SSI born on or after May 1, 2000, “Katie Beckett” children born on or after May 1, 2000, and children in adoption subsidy born on or after May 1, 2000, who are enrolled in RItE Care currently on a voluntary basis or are in Medicaid FFS. These children also receive the same benefits as other children.

The following children are excluded from participation in the RItE Smiles program irrespective of the membership in the population groups and continue to access their benefits through the State’s Medicaid FFS system:

- Children residing in a nursing home or an intermediate care facility for persons with intellectual/developmental disabilities (“ICF-I/DD”);
- Children with third-party coverage for dental benefits; and,
- Children residing outside of Rhode Island.

5.2. Introduction of the RItE Smiles 4-ALL Program

Since 2006, the State of Rhode Island has provided dental benefits to eligible Medicaid children enrolled in the Early Periodic Screening Diagnosis and Treatment (EPSDT) program through the RItE Smiles Medicaid managed care program. Due to the success of RItE Smiles, beginning in July 2022, EOHHS expanded enrollment in the existing RItE Smiles program to include young adults, born on or after May 1, 2000.

As of April 30, 2026 , there were 127,947 children and young adults born on or after May 1, 2000, enrolled in the RItE Smiles Program. For the remaining Medicaid eligible adults, dental benefits have been covered through the State’s traditional Fee-for-Service (FFS) program. As of April 30, 2026 , adult enrollment in the FFS Dental Program was 162,644 (excluding the young adults born on or after May 1, 2000).

EOHHS seeks to further align its delivery systems with this solicitation as the opportunity to transition the remaining adult Members out of the FFS dental delivery system and into a dental managed care delivery model. Contracting for dental service delivery results in a number of program improvements that will meet the EOHHS goals as previously stated. Upon implementation, the RItE Smiles 4-ALL Medicaid managed care dental program will include all eligible children and adults except for those groups listed below.

Eligible individuals in these three categories will continue to receive dental benefits through the State’s traditional FFS dental delivery system.

1. Individuals residing in a nursing home or an intermediate care facility for persons with intellectual/developmental disabilities (“ICF-I/DD”);
2. Individuals with third-party coverage for dental benefits; and,
3. Children residing outside of Rhode Island.

5.3. RItE Smiles (Legacy) Program Expenditures

Current dental service expenditures for children and young adults (by population group) using services in the current RItE Smiles program are depicted in the Table below. Data reflects SFY 2025 actual experience.

RItE Smiles Program Expenditures SFY 2025			
Population Group	Number of Dental Services	Number of Unique Members	Expenditures (in millions of dollars)
Adult Disabled	95	26	\$5,742
CSHCNs	29,980	4,145	\$1,499,011
Extended Family Planning (EFP)	<11 (10)	<11 (10)	\$40
Early Intervention (EI Only) *	<11 (10)	<11 (10)	\$153
Expansion	24,456	4,231	\$1,377,358
Foster Care	7,421	1,050	\$389,898
RItE Care	437,667	59,949	\$21,992,448
Total	499,619	69,401	\$25,264,651

* EI in Rhode Island is not a standalone basis for Medicaid eligibility. Rather, it is a service benefit that can be funded by Medicaid when a child is Medicaid-eligible under a qualifying eligibility group.

5.4. FFS Adult Dental Program Expenditures

SFY 2025 dental service expenditures for adults using dental services (by population group) in the current traditional FFS program are depicted in the Table below.

RI Adult Dental Program Expenditures SFY 2025			
Population Group	Number of Dental Services	Number of Unique Members	Expenditures In millions of dollars in managed care program
Adult Disabled	59,405	7,893	\$4,526,212
Aged	36,441	5,724	\$2,381,544
CSHCNs	230	35	\$12,839
Extended Family Planning (EFP)	48	16	\$3,536
Expansion	95,957	13,091	\$7,509,507
Foster Care	62	20	\$3,906
Medicare Premiums	82	23	\$4,740
RItE Care	92,833	12,151	\$6,791,643
Total	285,058	38,953	\$21,233,928

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6. Recent Developments and Challenges in the RI Medicaid Health Care Landscape

In recent years, EOHHS has made significant strides in addressing the unique challenges that impact the State's healthcare landscape. However, new issues continue to emerge. EOHHS is looking forward to partnering with MCOs who are committed to delivering innovative solutions to these ongoing challenges. The expectation is for contracted MCOs to actively collaborate and contribute to the resolution of future challenges and ensure Rhode Island's Medicaid Members have sustained access to quality dental services. Through feedback from recent public Listening Sessions and responses from a Request for Information (RFI), EOHHS has identified several ongoing challenges to address through this Solicitation, which include:

- The ongoing impact of the dental workforce shortage in RI on developing and maintaining a robust dental provider network that can provide the needed access to timely and appropriate dental care;
- Enhancing oral health outcomes across populations, prioritizing strategies for individuals with Intellectual and Developmental Disabilities (I/DD);
- Implementing an essential dental benefit to best serve individuals with intellectual and developmental disabilities (Members with special healthcare needs) that includes care coordination and clinical integration;
- The demand for improved community engagement and health education around healthcare systems;
- The need for high-quality data collection and analysis to provide insights into Members' unmet needs, disparities, and opportunities for improvement in the administration of Medicaid dental benefits;
- Gaps and challenges in offering a substantial healthcare service continuum, featuring medical and dental integration and parity with the current healthcare systems; and
- Lower costs associated with the delivery of dental care.

6.1. Strategic Priorities Under this Procurement

Access to quality and cost-effective oral health healthcare services is integral to meeting the diverse healthcare needs of Rhode Island's Medicaid Members. The purpose of this solicitation is to provide information and transparency regarding EOHHS's plans to introduce the RItE Smiles 4-ALL Dental Managed Care Program. The RItE Smiles 4-ALL Program aims to improve oral health outcomes for all Members, by focusing on integrating oral healthcare with overall healthcare through an effective care coordination and case management program. This solicitation includes program goals, objectives and design elements for the State's next generation of Medicaid dental managed care, a program that will be inclusive of all eligible Members irrespective of age.

EOHHS has prioritized the following areas and will hold the Dental Managed Care Contractor accountable for:

- Administering the RItE Smiles 4-All Program and achieving stated goals and objectives.
- Complying with EOHHS' policy and regulations regarding the RItE Smiles 4-All Program.

- Ensuring at-risk Members, including and not limited to children, mothers, and individuals with Special Health Care Needs receive timely access to medically necessary oral, medical, social and behavioral preventive and treatment healthcare services.
- Ensuring access to preventive focused, evidence-based practices, and high-value oral healthcare service excellence to prevent and reduce dental disease and overuse of the operating room for dental care.
- Ensuring an adequate network of primary and specialty dental providers.
- Ensuring all Members have a dedicated dental home.
- Linking mobile and portable dental services to Primary Care Physician (PCP) offices; non-dental Federally Qualified Health Center (FQHCs), school-linked and school-based programs; senior living facilities; and other community locations to increase access to care.
- Including non-traditional service models such as Teledentistry, use of Ambulatory Surgical Centers, and in-office sedation services to increase access and reduce costs associated with medically necessary dental care.
- Promoting performance-based provider reimbursement methodologies that reinforces value over volume as opposed to fee-for-service payments.
- Developing and implementing an effective system for disaster planning and recovery response.
- Minimizing fraud, waste and abuse and developing robust Program Integrity protocols to ensure the solvency of the RItE Smiles 4-ALL Program.
- Implementing a system of care coordination and case management to address and reduce health disparities by identifying Members' oral, medical, social and behavioral risk factors, and ensuring access to timely and appropriate healthcare services.
- Reducing complexity and streamlining administration for Providers and Members.
- Reducing use of the Emergency Department for non-traumatic dental care by collaborating and coordinating with the State's Medical MCOs.
- Increasing transparency regarding the Contractors' performance by publicly reporting metrics such as achievement of performance withholds and liquidated damages. This will help ensure accountability, promote payment transparency, and build community trust in the efficiency and cost-effectiveness of services delivered by contracted providers.
- Providing targeted audits of the RItE Smiles 4-ALL Program to ensure Contractors' accountability on a regular basis by EOHHS.
- EOHHS anticipates the Contractor(s) will demonstrate administrative efficiency and cost-effectiveness, and will systematically collect, analyze, and disseminate program-related data for continuous quality improvement. Proposals should speak to prevention and disease management strategies, network development and provider retention, utilization management, care coordination, cost containment, and specified Key Performance Indicators.

6.2. Desired System of Care and Care Continuum in RItE Smiles 4-ALL Program

EOHHS is committed to ensuring that all Members have access to high-quality healthcare services that are coordinated both at the system and provider levels, offering a seamless continuum of care

from birth throughout life. Members will have the opportunity to actively engage with their dental plan, health plan, and healthcare providers in ways that support health education, promote disease prevention, and ensure comprehensive coordination of services to help them achieve their highest level of health. Central to this approach is care coordination, which will be a core component of service delivery under the RItE Smiles 4-ALL Program, ensuring that each Member has a consistent source for medical and dental care, along with an accessible mechanism for coordinating their care.



It is expected that the RItE Smiles 4-ALL Bidder(s) will collaborate with the contracted Medicaid Medical Managed Care Plans (MCP) to coordinate care for Members needing services across multiple systems including and not limited to dental, medical, social and behavioral. EOHHS values linking such systems through care coordination and case management to promote access, use of benefits, and continuity of care.

As such, the RItE Smiles 4-ALL Bidder(s) should consider exploring innovative ways to collaborate with the Medical MCOs to ensure access to dental, medical, social and behavioral healthcare services through an integrated care coordination and case management administrative model. In addition, the RItE Smiles 4-ALL Bidder should consider service models that include mobile and portable dental service delivery to high-volume Primary Care Physician (PCP) offices; non-dental Federally Qualified Health Center (FQHCs), school-linked and school-based programs; senior living facilities; and other community-based service sites.

EOHHS intends for this Solicitation to serve as a platform for meaningful partnership with MCOs that demonstrate the capacity, commitment, and innovation necessary to address these challenges. Prospective bidders are expected to propose thoughtful, data-driven, and sustainable approaches that strengthen provider networks, advance equitable oral health outcomes, and integrate dental care within the broader healthcare system. Through collaborative engagement and shared accountability, EOHHS seeks to ensure continued access to high-quality, cost-effective dental services that meet the evolving needs of Rhode Island's Medicaid Members.

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Section B: Scope of Work and Requirements

Proposals must follow all instructions, conditions and requirements outlined within this solicitation. Appendix A to this solicitation is the stand-alone Medicaid RItE Smiles 4-All Program Model Contract (“Model Contract”), which details the scope of work for contracted Health Plans. The solicitation, incorporating the Model Contract, draft “RI Medicaid Dental Services Coverage Manual” and the Bidder’s related proposal by reference, are considered the contracts to be executed between selected Bidders and the State as described in Addendum F, “Agency Special Requirements”, Attachment F-2, “EOHHS General Terms and Conditions”, Attachment F-2, Section 2.2, “Agreement Order Precedence Hierarchy” of the Model Contract.

Bidders are expected to read this solicitation in its entirety before responding. Failure to follow any of the instructions, conditions and requirements set forth in this solicitation may result in a low score or disqualification.

Acceptable proposals must offer all required services identified in this solicitation, including the Model Contract in Appendix A and draft “RI Medicaid Dental Coverage Manual” and agree to the contract conditions specified throughout the solicitation and included in Bidder’s Technical Proposal response to Section C of this solicitation.

The solicitation Appendix A., Model Contract details the State’s requirements:

- Scope of Work (Attachment F-3);
- EOHHS General Terms and Conditions (Attachment F-2);
- Term of the Agreement (Attachment F-2; Section 1.4); and
- Terms and Conditions of Payment (Attachment F-2; Article 4).

The Model Contract substantially represents the contract document that the successful Bidder must agree to and sign as a condition precedent to being issued a Purchase Order by the State of Rhode Island.

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Section C: Proposal Requirements

1. General Requirements for Proposal Submission

1.1. General Requirements

A Bidder's Proposal to this solicitation shall consist of the following four (4) components:

1. Mandatory Qualification Documentation;
2. Business Proposal;
3. Technical Proposal;
4. Appendix with associated documentation.

Each bidder must submit proof of Mandatory Qualification, Business Proposal and Technical Proposal under this solicitation. The Proposal shall outline a Bidder's strategies to achieve the specified goals and outcomes, backed by evidence of past or current experiences.

Bidder proposals should not merely restate the expected outcomes, but the unique qualifications of the Bidder. Data showing improvements achieved should be provided to validate claims. Thoroughness and clarity are paramount. The Bidder may submit an additional Appendices with additional information relevant to the response, however, this is not required and is considered optional.

1.2. Proposal Response Format

The Bidder's proposal should respond to each item in the order in which it appears in Section 1.3. The Proposal should contain a Table of Contents, and each section should be separated by a tabbed page that includes headings and numbering to match the corresponding section of the solicitation.

Bidders shall not embed documents (e.g., copying a PDF within a Word document) within any document submitted as part of the Proposal.

1.2.1 Proposal Page Limits and the Inclusion of Diagrams, Graphics and Attachments

EOHHS urges Bidders to adhere to page limits wherever specified. Proposal responses should not exceed two-hundred fifty (250) pages in total for both the Business and Technical Proposal. Appendices are exempt from this page limit. Business Proposals may be no more than fifty (50) pages and Technical Proposals may be no more than two hundred (200) pages. EOHHS reserves the right to not evaluate any proposal contents beyond the two-hundred fifty (250) page limit. Any documentation not specifically requested will not be reviewed. Bidder proposal responses must be in narrative format.

Attachments such as graphics, flowcharts, diagrams, and tables should follow the narrative response for each section or sub-section under the Business Proposal and Technical Proposal Requirements. Attachments will not count towards the page limit and will not be considered in the evaluation or scoring, but may be utilized to provide additional information, as needed. Bidders should ensure that the material within the counted pages is fully responsive to the questions.

Cover pages and Table of Contents pages will not count towards the page limit of the proposals.

1.2.2 Proposal Style Requirements

This is an electronic submission. Submitted proposals must conform to the following style requirements:

- a. Proposal Composition: Proposals shall be divided into three PDF files: 1) Qualifications Documentation; 2) Business Proposal; 3) Technical Proposal; and 4) Appendices. Non-separation or co-mingling of PDF files may cause a Proposal to be immediately rejected and be deemed nonresponsive.
- b. File Type and Page Size: Files submitted must be in a searchable PDF format. Page size must be 8.5” x 11”, excluding pages with charts or graphics. Charts and/or graphs may be provided in a document size appropriate for electronic representation of the chart and/or graph. Optional key graphics, diagrams and flow charts may use 11”x 17” in ‘landscape’ orientation.
- c. Fonts and Margins: Proposals must be typewritten using black Times New Roman, Arial or Tahoma fonts, font size no less than 12-point font, with standard half-inch margins. Appendices must comply with font restrictions, but do not have to comply with the margin restrictions. Font size and color do not apply to graphics or diagrams in the Proposal. Original documentation submitted in the appendices do not need to conform with font and margin restrictions (i.e., financial statements or original business process documentation).
- d. Line Spacing: Proposals should be single-spaced.
- e. Headers: The header of each page should indicate the corresponding element to which the page is responsive and include the Bidder’s name. For instance, if the page is part of the Bidder’s response to 3.1 Organization and Experience, the header should indicate “3.1 Organization and Experience, Bidder’s Name.” Cover pages and table of contents do not need a header and footer label.
- f. Pagination/Footers: Page numbers should appear in the footer of each page, centered, and pagination should start at “1” for the beginning of each PDF. Cover pages and table of contents do not need a page number.
- g. Table of Contents: Each PDF file must contain a Table of Contents. The Table of Contents must link to the beginning of each corresponding response section. A table of contents should accompany any attachments or an appendix with associated documentation.
- h. Document File Naming Convention: The PDF Files must include the following file name convention:
 - Solicitation # _Document Name _Bidder Name
 - For the document name, please use the following abbreviations:
 - Mandatory Qualifications – “MQ”
 - Business Proposal – “BP”
 - Technical Proposal – “TP”
 - Appendices – “APP”
- i. Confidential or Propriety Information: Bidder is responsible for marking and submitting proposal materials to the specifications found on OSP.

1.2.3 Structure of Proposal with Corresponding Headers

All elements of the Proposal must be addressed in the sequence in which they appear within each Section of the table below and must adhere to the applicable maximum page limits.

The Bidder shall structure its Mandatory Qualifications, Business Proposal and Technical Proposal responses so that each proposal component is clearly identified and separated by a section line header or page break. Each response must use the headings and numbering that correspond exactly to the applicable solicitation Section identified in the table on the following page.

The Bidder shall ensure that all required elements are addressed under the corresponding section heading and that the organization and numbering of the Proposal allow for efficient review and evaluation against the solicitation requirements.

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1. Bidder Mandatory Qualifications	
1.1	Federal MCO Definition
1.2	Experience and Enrollment Requirements
1.3	No Exclusion
1.4	Capacity to Perform
1.5	US Principal Place of Business
1.6	Accreditation Requirements
1.7	No Sanction Requirements
2. Business Proposal Requirements	
2.1	Cover Letter
2.2	Executive Summary of Proposal
2.3	Attestation to Agree to Meet Program Rules and Requirements
2.4	Licensure and Certification
2.5	Disclosure of Non-Compliance, Warning Letters, Litigation and Early Termination
2.6	Network Providers Letters of Intent
3. Technical Proposal Requirements	
3.1	General
3.2	References
3.3	Dental Plan Administration
3.4	Eligibility and Program Enrollment
3.5	Dental Enrollment and Disenrollment
3.6	In-Plan Services
3.7	Care Coordination and Case Management
3.8	Provider Networks
3.9	Service Accessibility Standards
3.10	Marketing
3.11	Member Services
3.12	Provider Services
3.13	Quality Assessment and Performance Improvement
3.14	Utilization Management
3.15	Program Integrity, Fraud Prevention, and Compliance
3.16	Operational Data Reporting
3.17	Grievances and Appeals
3.18	Payments To and From Plans
3.19	Financial Standards
3.20	Record Retention
3.21	Compliance

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Section D: Required Proposal Components

1. Bidder Mandatory Qualifications

Bidder must provide attestation and supporting documentation demonstrating that it meets each of the seven (7) required qualification requirements to be eligible to bid on this award. Documentation must clearly substantiate compliance with each requirement and be included in the Mandatory Qualifications section of the Proposal.

- 1.1. Meet the federal definition of a managed care organization (MCO), as defined in 42. CFR § 438.2¹⁵;
- 1.2. Have a minimum of three (3) consecutive years of experience managing an array of medical, and or dental services covered by Medicaid and/or Medicare and serving a minimum combined total of fifty thousand (50,000) Medicaid, Medicare, or Medicaid-like¹⁶ members in one (1) or more U.S. states or territories;
- 1.3. Not an excluded individual or entity, as described in 42 CFR § 438.808(b)¹⁷;
- 1.4. Have the capacity and willingness to perform all functions in this solicitation, including the terms stipulated in Appendix A Model Contract, consistent with Medicaid managed care requirements defined in 42 CFR § 438¹⁸;
- 1.5. Have its principal place of business located within the United States;
- 1.6. Be currently accredited by a nationally recognized agency such as National Committee for Quality Assurance (NCQA) and/or Utilization Review Accreditation Commission (URAC) as defined in 42 CFR § 438.224¹⁹; and,
- 1.7. The Bidder, its corporate parent, or subsidiary of its corporate parent performing managed care services in another state has not been sanctioned, as defined in 42 CFR § 438.702²⁰, by a state or Federal government within the last ten (10) years.

2. Business Proposal Requirements

The contents of the Bidder's Business Proposal are essential minimum requirements for the Proposal, and these will be assessed on a Pass/Fail basis, except for the Cover Letter and Executive Summary, which are informational only. Bidders failing to meet all requirements in this section will not be considered responsive, and their proposal will not progress to the Technical Proposal evaluation stage. Only those

¹⁵ 42 CFR § 438.2 - <https://www.ecfr.gov/current/title-42/section-438.2>

¹⁶ Medicaid-like populations can broadly be defined as populations that have the following attributes: 1) Have low-income; 2) Must meet eligibility criteria that is determined by attributes or characteristics, such as family size, disability status, etc.; 3) Have complex health care needs or multiple comorbidities; or, 4) Includes vulnerable or underserved populations. A Bidder who is including Medicaid-like populations to qualify for Minimum Bidder Qualifications must justify how their covered lives meets the definitions as defined in this solicitation.

¹⁷ 42 CFR § 438.808(b) - <https://www.ecfr.gov/current/title-42/section-438.808>

¹⁸ 42 CFR § 438 - <https://www.ecfr.gov/current/title-42/part-438>

¹⁹ 42 CFR § 438.224 - <https://www.ecfr.gov/current/title-42/section-438.224>

²⁰ 42 CFR § 438.702 - <https://www.ecfr.gov/current/title-42/section-438.702>

who receive a passing score from the consensus of technical evaluation committee (TEC) on Sections 2.3-2.6 will have their Technical Proposals advanced for further review and evaluation. Any proposal not satisfying all Business Proposal Requirements will be dismissed without undergoing the Technical Proposal assessment by the TEC.

2.1. Cover Letter – Informational Only – Not Pass/Fail

The Business Proposal shall include a Cover Letter on the Bidder's letterhead. The cover letter is exempt from style and branding requirements as specified in Section 1.2.2.

The Cover Letter must include at a minimum the following information:

- 2.1.1 Legal Name of the Bidder
- 2.1.2 Location of the Bidder's administrative office with fulltime personnel;
- 2.1.3 Name and address of the Bidder's corporate principal if registered with the Rhode Island Secretary of State, email address, website URL, and telephone number;
- 2.1.4 Name and address of the Bidder's corporate office for the purpose of issuing checks and/or drafts;
- 2.1.5 Any other name(s) under which the Bidder does, or has done, within the last ten (10) years, business;
- 2.1.6 Ownership status (whether the bidding organization is publicly traded or privately held). If privately held, a statement listing name(s) and address(es) of the principal owners who hold more than five percent (5%) interest or more in the organization;
- 2.1.7 The type of legal entity (for example, corporation (profit or not for profit), limited partnership, general partnership, or trust), and the state where the entity is organized, including any parent organization;
- 2.1.8 If out-of-state Bidder, name and address of local representative; if not, so state;
- 2.1.9 If any of the Bidder's planned personnel is a current State of Rhode Island employee, or was employed by the State of Rhode Island within the past five (5) years, provide a listing to include the employee name, State agency, and separation date, if applicable;
- 2.1.10 A disclosure of any former State of Rhode Island employee within the past five (5) years used in the development and response to this solicitation, including a listing to include the employee name, State agency, and separation date, if applicable;
- 2.1.11 Description how the Bidder satisfies Section A, 1.4.1 Eligibility requirements contained in this solicitation;
- 2.1.12 Description how Bidder has met and satisfied the Minimum Bidder Qualification contained in this solicitation contained in Section A, 1.4.2, including attaching any relevant documentation demonstrating minimum qualifications;
- 2.1.13 Description how the Bidder has met or will meet regarding the attributes of a qualified Bidder as described in Section A, 1.4.3;
- 2.1.14 Disclosure of the Bidder is current a Qualified Health Plan on the Rhode Island Health Insurance Exchange or its commitment to become a QHP within two (2) years of a contract award;

- 2.1.15 Bidder's State and federal tax identification numbers, if available; and,
- 2.1.16 List of proposed Major Subcontractors the Bidder plans to utilize under this Agreement and their expertise to perform the work under the Model Contract. Please indicate the number of years the Bidder has a working relationship with the Major Subcontract and how the Bidder perform oversight of the Major Subcontractor. The Bidder is encouraged to attach all Major Subcontractor agreements or MOUs and the intended work performed with the Subcontractor related to this Bid.

2.2. Executive Summary – Informational Only – Not Pass/Fail

The Bidder should provide an executive summary of the proposal that includes at least the following information:

- 2.2.1 Bidder's understanding of the services requested in the solicitation and the problems presented;
- 2.2.2 Bidder's familiarity with the program's elements, populations to be served, and the Rhode Island healthcare system and the Medicaid Program at a national and state-level;
- 2.2.3 Bidder's capability to meet or exceed the requirements in the Model Contract; and,
- 2.2.4 Areas the Bidder wishes to note as particularly innovative and demonstrative of the Bidder's commitment to meaningfully participating in the Rhode Island Medicaid Managed Care Program and in partnering with EOHHS to accomplish Procurement Goals in Section A of this solicitation.

2.3. Attestation to Program Rules and Requirements

The Bidder shall develop and submit an attestation signed by the owner, officer or other authorized agent of the Bidder or organization. The attestation shall expressly state that the Bidder has read, understands, acknowledges, and accepts the terms and conditions of this solicitation. To be responsive to this section, the Bidder's attestation must specifically address and include all of the following elements. The Bidder is responsible for ensuring that each required element is incorporated into the attestation submitted with its Bid.

- 2.3.1 A statement that the Bidder has a thorough understanding of the Rhode Island Medicaid Managed Care Program and the Rhode Island health care environment;
- 2.3.2 A statement that the Bidder has reviewed and comprehends the solicitation objectives and affirms its capability to perform in accordance with the Agreement terms and conditions including meeting and exceeding performance standards and/or performance metrics.
- 2.3.3 A statement that the Bidder acknowledges and understands the risks involved in the Rhode Island Medicaid Managed Care Program as described in the solicitation, including the risk of non-appropriation of funds.
- 2.3.4 A statement that the Bidder meets all the Minimum Bidder Qualification in Section A, 1.4.2 of this solicitation.
- 2.3.5 A statement that the Bidder has read, understands, and accepts the conditions and limitations of this solicitation, Appendix A Model Contract, and the "RI Medicaid

Dental Services Coverage Manual”.

- 2.3.6 A statement that the Bidder attests to the accuracy and truthfulness of all information contained in the Bidder’s responses to the solicitation.
- 2.3.7 A statement that the Bidder accepts the State’s Fiscal and Performance Requirements as set forth in F-3 the Scope of Work and the actuarial rate development and rate setting process outlined in “State Fiscal Year 2027 RIte Smiles 4-All Illustrative Capitation Rates July 1, 2026 through June 30, 2027, dated July 30, 2026” found in Appendix C.
- 2.3.8 A statement that the Bidder is a health maintenance organization (HMO) that is either licensed by the Rhode Island Department of Business Regulation (DBR) or will receive HMO licensure or approval to conduct business in Rhode Island no later than sixty (60) days after execution of this Agreement.
- 2.3.9 A statement of attestation that the Bidder is in good standing with and has not been debarred from participation in any Federal or Federal/State health care programs, including Medicare, CHIP, and any state Medicaid program.
- 2.3.10 The Bidder shall attest that the entity or entities responsible for administering the RIte Smiles 4-ALL program hold or shall obtain within twenty-four (24) months after Contract execution, applicable NCQA accreditation or certification for the managed care functions performed under the Contract. A Medicaid managed care organization or medical managed care organization may satisfy this requirement through current NCQA Health Plan Accreditation, including the Medicaid line of business where applicable, only if the accreditation scope expressly applies to the Rhode Island Medicaid dental program and the dental benefit functions performed under this Contract. If a dental-only managed care organization, dental benefits administrator, subcontractor, or delegated dental entity does not hold full NCQA Health Plan Accreditation, it must hold or timely obtain applicable NCQA accreditation or certification for the critical functions it performs, including Credentialing Accreditation or CVO Certification, Utilization Management Accreditation, Provider Network Accreditation or State-approved equivalent NCQA status, and documented delegation oversight. The Bidder shall remain fully accountable for all delegated functions and shall provide copies of current NCQA or URAC decision letters, certificates, scope descriptions, expiration dates, corrective action requirements, and a crosswalk identifying each RIte Smiles 4-ALL program function, the performing entity, the applicable accreditation or certification status, and whether the status is current or planned. The State reserves the right to determine whether any accreditation or certification is sufficient based on legal entity, scope, product line, delegated arrangements, and applicability to the Rhode Island Medicaid dental program; failure to obtain or maintain required status may result in corrective action, sanctions, payment withholding, suspension of delegated functions, or termination.
- 2.3.11 The Bidder shall attest that it holds or will obtain within twenty-four (24) months after Contract execution, NCQA Health Outcomes Accreditation, formerly NCQA Health Equity Accreditation and evolved from NCQA Distinction in Multicultural Health

Care, or a State-approved successor or substantially equivalent NCQA accreditation. The accreditation must apply to the entity responsible for administering the RItE Smiles 4-ALL program and must cover the populations, services, data systems, language access, provider network, quality improvement, and disparity-reduction activities relevant to the RItE Smiles 4-ALL Program benefits. NCQA Health Plan Accreditation alone shall not satisfy this requirement unless the Bidder demonstrates that the applicable NCQA-reviewed health equity functions apply to the RItE Smiles 4-ALL program. Dental-only plans or dental benefits administrators shall remain eligible if they hold or timely obtain the required accreditation for the RItE Smiles 4-ALL program functions and covered population. The Bidder shall submit supporting NCQA documentation or, if not yet accredited, a detailed implementation plan with scope, milestones, interim controls, and accountable leadership.

- 2.3.12 A statement of attestation that the Bidder and its Subcontractors have the requisite skills, qualifications, expertise, financial resources, and experience necessary to provide the services and deliverables described in the solicitation, the Bidder's Proposal, and the Model Contract in an efficient, cost- effective manner, with a high degree of quality and responsiveness.
- 2.3.13 A statement of attestation that the Bidder abides by Affirmative Action Policies and Procedures and that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act.
- 2.3.14 A statement of attestation that the Bidder has no moral or religious objections to providing any of the Covered Benefits described in Addendum F, "Agency Special Requirements", Attachment F-4.1, "Schedule of In-Plan Benefits" in the Model Contract including any new covered services added during the term of the Contract. If the Bidder does have any moral or religious objections under any of the benefits contained within the Model Contract, the statement must describe, in as much detail as possible, all direct and related services that are objectionable. It must include a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If there are none, it must so state.
- 2.3.15 The Bidder certified that no elected or appointed official or employee of the State of Rhode Island has or will benefit financially or materially from any contract resulting from this solicitation. The State may terminate a resulting contract if it is determined that gratuities of any kind were either offered or received by any of the aforementioned officials or employees from the Bidder or its agents or employees.
- 2.3.16 The Bidder assures that the submitted proposal is not made in connection with any competing organization or competitor submitted a separate proposal in response to this solicitation. No attempt has been made, or will be made, by the Bidder to induce any organization or competitor to submit, or not submit, a proposal for the purposes of restricting competition.

- 2.3.17 The Bidders attests to obtaining prior written consent and approval from RIDOP and EOHHS related to award announcements for this Agreement, including any publicity related to the subsequent award.
- 2.3.18 The Bidder agrees to become a Qualified Health Plan (QHP) on Rhode Island's Health Insurance Exchange within two (2) years of the operational start date of an awarded Contract. The Bidder attests to EOHHS that its operations are not based outside of the United States. Furthermore, the Bidder agrees to not include any claims paid to any provider located outside of the United States in its encounter data reporting to EOHHS, or to EOHHS' FI or Actuary during the terms of the Agreement (42 CFR §438.602(i)²¹).

2.4. Licensure and Certification

The Contractor shall attest that it is licensed in Rhode Island as an HMO pursuant to RI Gen. Laws Chapter 27-41²², or will obtain licensure as an HMO or Health/Dental Plan (HP) from the Rhode Island Department of Business Regulation (DBR) prior to execution of an Agreement with EOHHS. If not licensed as an HMO, the Contractor certifies it is otherwise licensed by DBR under applicable Rhode Island General Laws and meets the requirements of RI Gen. Laws § 27-18.9-8²³, and is certified as a utilization review entity by a nationally recognized utilization management organization. The Contractor shall forward to EOHHS any complaints received from DBR or OHIC and copies of related correspondence regarding managed Medicaid network contract status. The Contractor shall notify EOHHS of any person or corporation with five percent (5%) or more ownership or controlling interest in the Contractor. At least annually, and within thirty (30) days of any change in accreditation, the Contractor shall notify EOHHS of its accreditation status and authorize the accrediting entity to provide EOHHS applicable accreditation review materials in accordance with 42 CFR §§ 438.332(b)(1)–(3)²⁴.

- 2.4.1 Please describe your organization's current licensure status in Rhode Island (e.g., HMO under RI Gen. Laws Ch. 27-41²⁵, nonprofit hospital/medical service corporation under Ch. 27-19²⁶ or Ch. 27-20²⁷, or other DBR-licensed health insurance entity). If not currently licensed, describe your plan and timeline to obtain licensure prior to contract execution.
- 2.4.2 Does your organization comply with the requirements outlined in the Rhode Island Benefit Determination and Utilization Review Act (RI Gen. Laws § 27-18.9-8²⁸), specifically regarding external appeal procedural standards, and can you provide documentation or a detailed description of your compliance?
- 2.4.3 Is your organization certified as a utilization review entity by a nationally recognized health utilization management organization? Please provide certification details and

²¹ 42 CFR §438.602(i) - <https://www.ecfr.gov/current/title-42/section-438.602>

²² RI Gen. Laws Chapter 27-41 - webserver.rilegislature.gov/Statutes/TITLE27/27-41/INDEX.htm

²³ RI Gen. Laws § 27-18.9-8 webserver.rilegislature.gov/Statutes/TITLE27/27-18.9/27-18.9-8.htm

²⁴ 42 CFR §§ 438.332(b)(1)–(3) - <https://www.ecfr.gov/current/title-42/section-438.332>

²⁵ RI Gen. Laws Ch. 27-41 - webserver.rilegislature.gov/Statutes/TITLE27/27-41/INDEX.htm

²⁶ RI Gen. Laws Ch. 27-19 - <https://webserver.rilegislature.gov/Statutes/TITLE27/27-19/INDEX.htm>

²⁷ RI Gen. Laws Ch. 27-20 - <https://webserver.rilegislature.gov/Statutes/TITLE27/27-20/INDEX.htm>

²⁸ RI Gen. Laws Ch.27-18.9-8 - <https://webserver.rilegislature.gov/Statutes/TITLE27/27-18.9/27-18.9-8.htm>

effective dates.

2.5. Disclosure of Non-Compliance, Warning Letters, Litigation and Early Termination

For purposes of responding to this section, type of non-compliance include: compliance letters (includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans (CAPs) or similar state notices); adverse performance audits (contracts failing more than fifty-percent (50%) of audit elements); adverse financial audits (adverse opinions or disclaimed reports); failures to maintain fiscally sound operations (negative net worth or financial loss greater than half of the Bidder's total net worth); exclusions enforcement actions (imposed by CMs as an intermediate sanction); and all other significant compliance concerns.

- 2.5.1 Identify and describe all instances of noncompliance that the Bidder, its parent company/organization, and affiliates have encountered as part of any Medicaid or Medicare managed care contracts within the past five (5) years. For each non-compliance issued, the Bidder shall indicate the type of non-compliance issued, the date the non-compliance was issued, and the reason the non-compliance was issued, the issuing agency in which the Bidder was providing services for which the non-compliance was issued, and any and all details of the sanctions applied against the Bidder as a result of non-compliance.
- 2.5.2 Bidder must disclose all noncompliance of Material subcontractor to the Bidder's Proposal in the past five (5) years.
- 2.5.3 Identify all instances of non-renewal or early termination of Medicaid or Medicare contracts within the past ten (10) years. The Bidder shall specify the type of contract, why the termination was initiated, and by whom it was initiated (Bidder, state, mutual, or federally imposed).
- 2.5.4 Bidder must disclose all litigation in the past five (5) years for itself and any proposed Major Subcontractors.

2.6. Network Providers Letters of Intent

The Bidder must complete the Provider Letter of Intent Form (Appendix D) to demonstrate its ability to secure a robust provider network with a sufficient volume and array of providers enabling the delivery and access all Medicaid covered services. This form is not a binding contract. It is meant to provide the state with an estimate of providers that have indicated their intention to enter a contract with the Bidder by the effective date of this new contract. Please review Appendix D for further details and instructions on the completion of the Provider Letter of Intent Form.

3. Technical Proposal Requirements

The Bidder's response to each of the following technical proposal requirements (Sections 3.1 – 3.21) will receive a numerical score as identified in Section D: Evaluation and Selection. The responses should demonstrate, using relevant data, the Bidder's understanding of the Rhode Island health care landscape and Medicaid population, including challenges and opportunities related to health care delivery, and unique approaches to providing Rhode Island Medicaid services to the population covered under this solicitation.

Responses should demonstrate the potential for innovation and increased value inherent in a managed care structure and not available in the FFS delivery system. These questions reflect State priorities and should address, where applicable, racial disparities, community collaboration, and person-centered design even if the question does not expressly state those themes. If the Bidder does not currently have a Medicaid managed care contract with EOHHS, the Bidder should select a current market or product to use in the responses to questions regarding current policies, procedures, or experiences, and must name the market or product selected. The Technical Proposal response is limited to two hundred (200) pages; however, Bidders are encouraged to include relevant data, graphics, figures, tables etc. as appropriate to supplement their response to the question. Attachments, including graphics, flowcharts, diagrams, tables, sample materials, and any other items included as attachments, do not count toward the maximum page limit.

3.1. General

The Contractor shall comply fully with all operational and financial standards set forth in the Agreement and shall provide, or arrange for the delivery of, covered dental care services to eligible Medicaid Members statewide in exchange for capitation payments. EOHHS and the Contractor will work collaboratively during an initial planning period to identify opportunities for program improvement and to support achievement of program goals, including improving access, utilization, and oral health outcomes; reducing disparities; prioritizing improved outcomes for adult Members with I/DD; streamlining administrative processes; implementing innovative care coordination, delivery, and payment strategies; and reducing overall costs. In accordance with 42 CFR § 438.6²⁹, the Contractor retains full legal responsibility for performance of all contract requirements, including services provided through subcontractors.

3.1.1 Strategy

- 3.1.1.1. Describe your organization's strategy to improve access and utilization of dental care for Medicaid Members.

3.1.2 Collaboration with EOHHS

- 3.1.2.1. Please describe how your organization will collaborate with the Executive Office of Health and Human Services (EOHHS) during the planning period to identify opportunities for program enhancement and improvements that align with state objectives and Member needs.

3.1.3 Principal Obligations

- 3.1.3.1. The Contractor and all Subcontractors shall fully cooperate with EOHHS and applicable healthcare oversight agencies, including the Rhode Island Office of the Attorney General and the Medicaid Fraud Control Unit (MFCU), by responding within required timeframes to all requests for information, records, or data related to services provided under this Agreement, including those involving Major Subcontracts that manage or coordinate Member benefits. The Contractor and its Subcontractors shall furnish requested information at no cost to EOHHS or MFCU and without requiring EOHHS or MFCU to enter into any separate contract, agreement, or memorandum of understanding. The

²⁹ 42 CFR § 438.6 <https://www.ecfr.gov/current/title-42/section-438.6>

Contractor and its Subcontractors acknowledge that this Agreement establishes an enforceable right for healthcare oversight agencies to obtain such information and that these rights may be enforced through legal action in the event of non-compliance. The Contractor shall also cooperate with EOHHS, CMS, the External Quality Review Organization (EQRO), and any other EOHHS contractors engaged in the operation, evaluation, and monitoring of this Agreement and the Rhode Island Medicaid Managed Care Program.

- 3.1.3.2. What systems and protocols does your organization have in place to ensure timely responses to information requests from EOHHS, the Attorney General's Office, and the Medicaid Fraud Control Unit (MFCU)?

3.2. References

- 3.2.1 Bidders will be required to provide programmatic references for the submission of the Proposal. The Bidder shall provide a list of:
- Three (3) professional programmatic references;
 - One (1) reference for a currently enrolled member of the Bidder at the time of the proposal submission; and;
 - One (1) reference for each proposed Material Subcontractors that would have Member or Provider-facing duties (if applicable).
- 3.2.2 References are to be provided for work completed within the last three (3) years and must be for professional services of similar scope and focus to this solicitation.
- 3.2.3 References shall include the organization's name, the name of the specific contact person in the organization, a backup contact, a summary of the services the organization provides, the relationship of the contact to the Bidder, the mailing address, telephone number, and email address of a specific contact person. At its discretion, EOHHS may check or contact any reference provided by the Bidder.
- 3.2.4 The following individuals cannot serve as references under this solicitation:
- Any current or former Rhode Island EOHHS employee who has provided oversight of the Rhode Island Medicaid Managed Care Program within the past five (5) years at the time of the Proposal submission;
 - Board Member or affiliates of a Bidder; or,
 - Family members, either through blood or marriage, of the Bidder.
- 3.2.5 EOHHS may contact these references and consider the information obtained as part of the evaluation process. By submitting the references, the Bidder is specifically authorizing EOHHS to contact them regarding this solicitation and any and all information the reference has regarding the Bidder. To the extent a written authorization or release is required by any reference provider, the Bidder agrees to provide one upon request. For each selected reference, including the following information:
- The type of reference (i.e., Other state Medicaid agency, Provider, advocate, etc.);
 - The reference's name, title, and employer;

- The reference's contact information, including phone number, email address, and physical address;
- The nature of the relationship, including the capacity in which the reference is familiar with the Bidder's organization;
- The time period of the relationship;
- Activities undertaken during the engagement that establish the Bidder's qualifications for this solicitation;
- Best time of day for EOHHS to contact the reference.

3.3. Dental Plan Administration

This section establishes the Contractor's administrative, staffing, governance, and operational obligations for administering RItE Smiles 4-ALL. The Contractor must maintain an in-state administrative presence, qualified and sufficient staffing, required key personnel and executive leadership, appropriate training, written policies and procedures, and organizational structures capable of meeting all contractual, program, compliance, reporting, and service delivery requirements. Key personnel must generally be full-time, Rhode Island-based, dedicated to the Agreement, and subject to EOHHS approval, oversight, reporting, and replacement requirements.

The Contractor acknowledges EOHHS's expectations for ethical governance, Board of Directors conduct, employment practices, prohibited affiliations, ownership disclosures, operational planning, business continuity, disaster recovery, security, cooperation with EOHHS and other entities, and compliance with applicable State and Federal laws. EOHHS retains broad oversight authority, including the right to require corrective action, approve or revoke staffing exceptions, request documentation, require training, assess remedies or liquidated damages, and direct changes necessary to ensure contract performance and continuity of services.

3.3.1 General

- 3.3.1.1. Provide an organizational chart and outline with strategy for ensuring adequate administrative staffing and organizational infrastructure to meet all program requirements.
- 3.3.1.2. How will your organization establish and demonstrate a strong presence within the state, including efforts in outreach, marketing, and active involvement in community and health-related events.

3.3.2 Administrative Office Requirements

- 3.3.2.1. Describe how your organization will establish and maintain a non-residential administrative office in Rhode Island within twenty-five (25) miles of the Virks Building in Cranston, including the office's planned location, hours of operation, available technology, and ability to support general administrative functions.
- 3.3.2.2. Describe how you will ensure EOHHS has direct access to Key Personnel and administrative support, including dedicated telephone and email contacts, updated contact information, workspace for EOHHS staff upon request, document reproduction capabilities, facsimile capacity, and high-speed Internet

connectivity.

3.3.3 Organizational Staffing Requirements

- 3.3.3.1. Describe how your organization will recruit, develop, train, and retain qualified staff in sufficient numbers to meet all Rhode Island Medicaid Managed Care Dental Program requirements, including culturally competent services, continuity of operations during personnel changes, and achievement of contractual performance outcomes.
- 3.3.3.2. Describe your proposed organizational and governance structure for this program, including executive management authority, Rhode Island-based Key Personnel, reporting relationships, major subcontractors, vacancies, and how you will maintain and promptly update organizational charts during Readiness Review and throughout the contract term.
- 3.3.3.3. Describe how you will ensure workforce compliance and accountability, including screening employees and subcontractors against required exclusion and adverse action databases, conducting required background checks, providing staff for mandatory EOHHS meetings, notifying EOHHS of Key Personnel departures or extended absences, and removing or reassigning personnel upon EOHHS request.

3.3.4 Contractor's Key Personnel Requirements

- 3.3.4.1. Identify the individuals you propose to serve as Key Personnel and describe how you will ensure each person meets the required commitment expectations, including full-time Rhode Island-based service, one hundred percent dedication to this Agreement, and assignment to only one Key Personnel role unless EOHHS grants written approval.
- 3.3.4.2. Describe how you will maintain continuity in Key Personnel roles, including timely written notice to EOHHS of changes, use and duration of interim staffing, replacement with qualified personnel, and resolution of EOHHS concerns regarding the working relationship or performance of any Key Personnel

3.3.5 Contractor's Key Personnel

- 3.3.5.1. Describe how you will ensure all required Key Personnel and functional leads are identified, assigned to this Agreement, and in place within the timeframe established by EOHHS during Readiness Review.
- 3.3.5.2. Describe your proposed staffing approach for the required executive, clinical, operational, compliance, technology, member services, provider network, quality, care management, claims, reporting, program integrity, EPSDT, value-based care, and fraud, waste, and abuse functions, including which positions will be Rhode Island-based, located outside Rhode Island, or deployed throughout Rhode Island to best serve Members.

3.3.6 Contractor's Requirements for Executive Management Functions and Executive Leadership

- 3.3.6.1. Describe how your Executive Management team will be structured for this Contract, including the proposed CEO, CFO, COO, Rhode Island Medicaid Contract Officer, Dental Director, CTO, and Chief Compliance Officer, and how each role will meet the required qualifications, authority, reporting relationships, and Rhode Island-based availability expectations.
- 3.3.6.2. Describe how your Executive Management team will support EOHHS oversight and responsiveness, including attendance at meetings in Rhode Island with or without notice, use of approved delegates when necessary, timely responses to EOHHS, legislative, financial, operational, technology, clinical, and compliance inquiries, and prompt resolution of issues or disputes.
- 3.3.6.3. Describe how you will manage Executive Management changes and continuity, including advance notification to EOHHS of acting or permanent appointments, one-business-day notice of changes, submission of a transition plan within five business days, annual or requested updates to required tables and resumes, and role-specific continuity for the Dental Director.
- 3.3.7 Contractor's Executive Management Compensation and Salary Transparency Reporting for Contractor's Key Personnel
 - 3.3.7.1. Describe how your organization will prepare and submit the annual Executive Management compensation report to EOHHS, including individual-level reporting of total compensation for all required Executive Officers and Executive Leaders, separation of Medicaid and Medicare compensation from commercial plan compensation, inclusion of all required compensation components, and support for any additional EOHHS reporting or public transparency requirements.
- 3.3.8 Substitution of Personnel
 - 3.3.8.1. Describe your organizational process for requesting, approving, and implementing substitutions of personnel assigned to this Contract, including how you will notify EOHHS, ensure replacement personnel meet or exceed required qualifications, maintain continuity of operations, and avoid any disruption to contractual performance.
- 3.3.9 Contractor's Key Personnel Conduct
 - 3.3.9.1. Describe how you will train Key Personnel and call center staff before they have public contact or answer scheduling lines, including training on member-sensitive communications, cultural competency, aged and disabled populations, hostile callers, hearing or speech-impaired individuals, managed care operations, Member Services supports, correction of inappropriate conduct, and submission of the Training Plan and any updates to EOHHS.
- 3.3.10 Contractor's Board of Directors and Ethical Conduct of Board Members
 - 3.3.10.1. Describe how your organization will maintain transparency regarding your Board of Directors, including submission of Board membership during Readiness Review, notification to EOHHS of changes within two Business

Days, timely website updates, and disclosure of any substantial financial interests or actual or perceived conflicts of interest.

- 3.3.10.2. Describe how you will ensure ethical, conflict-free conduct by Board Members in all matters related to this Contract, including adoption of an EOHHS-approved Code of Ethics in the Board bylaws, required conflict disclosures, compliance with applicable laws and nondiscrimination standards, investigation and reporting of alleged violations, and removal or other corrective action when required by EOHHS.

3.3.11 Contract Administration

- 3.3.11.1. Describe how your organization will manage contract administration and communications with EOHHS, including identifying the Contractor representative responsible for all Agreement matters, coordinating through the EOHHS Contract Officer or designated liaison, routing issues appropriately before escalating to other State officials, and responding to official notices regarding performance requirements or contractual remedies.

3.3.12 Notification of Administrative Changes

- 3.3.12.1. Describe how your organization will identify, evaluate, and notify EOHHS of any material changes to your operations, staffing, or systems that could affect contract administration or performance, including how you will obtain EOHHS approval at least thirty Calendar Days before implementation and support any additional Readiness Review required by EOHHS.

3.3.13 Responsibility for Contractor's Representatives

- 3.3.13.1. Describe how you will ensure that all Contractor Representatives remain under your sole direction and control and are not presented or treated as employees, agents, or representatives of EOHHS or the State of Rhode Island.
- 3.3.13.2. Describe how you will assume responsibility for the acts, omissions, employment-related claims, damages, and liabilities of your Representatives, including how you will inform personnel that they are not entitled to State employment benefits or indemnification and how you will indemnify and hold harmless EOHHS and the State from related claims.

3.3.14 Written Policies, Procedures, and Job Descriptions

- 3.3.14.1. Describe how your organization will develop, maintain, review, and approve written policies, procedures, and job descriptions for each functional area, including consistent formatting, written development and approval guidelines, annual review requirements, required signatures or committee approval documentation, Dental Director approval of dental and quality management policies, and annual validation that job descriptions reflect current duties.

3.3.15 Staff Training, Licensure, and Meeting Attendance

- 3.3.15.1. Describe how your organization will ensure that all staff and Subcontractors meet applicable licensure, certification, credentialing, orientation, education, experience, and training requirements before performing work under this

Contract, including how you will restrict non-compliant personnel from performing work and document completion of EOHHS-required mandatory training.

- 3.3.15.2. Describe your approach to initial and ongoing staff training for this program, including training on the RIte Smiles 4-ALL requirements, job-specific State and Federal requirements, health equity, HSRN, SDOH, CLAS, quality of care concerns, Advance Directives, cybersecurity, Rhode Island geography and culture, and how you will make training materials, agendas, attendance records, meeting minutes, and action items available to EOHHS upon request.

3.3.16 Cooperation with other Entities

No response is required for this section.

3.3.17 Employment Practices

No response is required for this section.

3.3.18 Employment of State Personnel

No response is required for this section.

3.3.19 Payments to Institutions or Entities Located Outside of the United States

No response is required for this section.

3.3.20 Prohibited Affiliations

No response is required for this section.

3.3.21 Disclosure of Contractor's Ownership and Control Interest

- 3.3.21.1. Describe how your organization will collect, certify, submit, and update complete ownership and control interest disclosures in accordance with 42 CFR § 455.104³⁰, including required information for owners, controlling entities, managing employees, related parties, and subcontractors in which you hold a five percent or greater interest.

- 3.3.21.2. Describe how you will ensure timely disclosure and transparency, including submission with your proposal, upon execution, renewal, or extension of the Contract, within thirty-five Calendar Days of any ownership change or written request, CEO/CFO-level certification of accuracy, and website posting of required individuals and titles in accordance with 42 CFR § 438.602³¹.

3.3.22 Employee Education about False Claims Recovery

- 3.3.22.1. Describe how you will educate employees, management, Subcontractors, and agents about False Claims Act requirements, administrative remedies, applicable State false claims laws, whistleblower protections, and your policies and procedures for detecting and preventing Fraud, Waste, and Abuse, including how this information will be incorporated into written policies and employee handbooks when applicable.

³⁰ 42 CFR § 455.104 - <https://www.ecfr.gov/current/title-42/section-455.104>

³¹ 42 CFR § 438.602 - <https://www.ecfr.gov/current/title-42/section-438.602>

3.3.23 Operational Planning Documents

- 3.3.23.1. Describe how your organization will develop, maintain, and annually review required operational planning documents, including the Disaster Recovery Plan, Business Continuity Plan, Security Plan, Joint Interface Plan, Risk Management Plan, Systems Quality Assurance Plan, and Continuity of Operations Plan.
- 3.3.23.2. Describe your approach to disaster recovery and systems contingency planning, including procedures for responding to damaged or failed technology infrastructure, protecting data availability and integrity, maintaining off-site backups, identifying projected recovery times and data loss for mission-critical systems, and restoring systems, networks, applications, and operations.
- 3.3.23.3. Describe how your organization's Continuity of Operations Plan will maintain Contractor, Material Subcontractor, and subcontractor operations during a pandemic, natural disaster, man-made emergency, utility loss, staffing disruption, or other significant operational disruption, including communication with EOHHS, Members, Network Providers, employees, and contractors.
- 3.3.23.4. Describe how you will address Member access to care during emergencies, including implementation of EOHHS directives, relaxation of authorization requirements when directed, extension and transfer of Prior Authorizations to new providers, and emergency preparedness planning for Enrollees with Special Health Care Needs in accessible formats.
- 3.3.23.5. Describe how your organization will test, document, submit, update, and invoke your Continuity of Operations and systems contingency plans, including annual simulated disaster or lower-level failure testing, submission of testing documentation, corrective action within ten Business Days if testing fails, EOHHS approval during Readiness Review and before changes, and immediate notification when the plan is invoked.

3.3.24 Independent Contractor Status

No response is required for this section.

3.3.25 RI Works Participants

No response is required for this section.

3.4. Eligibility and Program Enrollment

3.4.1 Eligible Populations

RIte Smiles 4-ALL eligible population consist of different eligibility groups including: Rite Care; Children with Special Health Care Needs; Rhody Health Partners; Affordable Care Act Eligible Population (Expansion Adults); and Dual Medicare-Medicaid Members. Qualification for RIte Smiles 4-ALL is based on a combination of factors, including family composition, income level, insurance status, and/or pregnancy status. The scope of dental benefits, program cost sharing options/requirements and enrollment procedures vary by eligibility group aid and are described in detail in the Model Contract, Attachment 1.

- 3.4.1.1. Provide a statement of your understanding of the eligible population groups for which your organization will be responsible for administering benefits.

3.5. Dental Plan Enrollment and Disenrollment

3.5.1 Dental Plan Enrollment Procedures

The State shall conduct Medicaid enrollment activities for all eligible children and adults and will enroll Members into the RIte Smiles 4-ALL program, providing the Contractor with monthly enrollment files in the State's designated data format. The Contractor shall maintain written policies and procedures for enrollment, with coverage effective the first (1st) day of the month following State notification and shall mail enrollment notices to Members within ten (10) days of receiving enrollment notification, including the effective date and instructions for accessing care. The Contractor shall enroll all eligible Members in the order of selection or assignment and shall not discriminate, nor apply policies that have the effect of discriminating, based on race, color, national origin, sex, sexual orientation, disability, age, ethnicity, language needs, health status, or need for health services. The State may conduct open enrollment at mutually agreed times and may apply family and assignment requirements, including sibling alignment, market share limitations, and a ninety (90) day period for Members to change plans following auto-assignment, in accordance with Agreement terms.

- 3.5.1.1. Describe your organization's policies and procedures for enrolling new Medicaid Members, including timelines for notifying Members of their enrollment and ensuring timely access to care. Explain how you will ensure that enrollment is conducted without discrimination based on race, color, national origin, sex, sexual orientation, disability, age, ethnicity, language needs, health status, or need for health services. Detail your approach to open enrollment, including Member choice, family unit assignment, and auto-assignment processes. Additionally, provide copies of your written enrollment policies and procedures that address the requirements outlined in this contract, and describe how you will ensure timely and accurate acceptance of enrollment information in the format submitted by the State.

3.5.2 Change in Member Status

Accurate and timely Member information is essential to effective program administration and care coordination. The Contractor is expected to maintain processes to identify and communicate changes in Member status—such as updated contact information, household changes, deaths, out-of-state residence, or third-party liability—to support proper enrollment records, outreach, and service delivery. These processes should include proactive outreach efforts to confirm the most current Member address and telephone number and should extend to subcontractors, who must be aligned with the Contractor's reporting and communication procedures.

- 3.5.2.1. Describe the processes your organization will use to report changes in Member status—such as address, phone number, residence, death, household composition, or third-party liability—within five (5) days. Explain how your organization will conduct outreach and verification to ensure Member contact information is accurate, and detail how you will ensure that subcontractors

comply with all requirements related to reporting Member status changes.

3.5.3 Enrollment and Disenrollment Updates

Timely access to an accurate monthly Member roster is essential to effective program administration, including enrollment management, outreach, reporting, and service coordination. To support these functions, EOHHS will provide the Contractor with a full roster of enrolled Members during the second financial cycle of each month, and the Contractor is expected to maintain written policies and procedures to receive these updates and incorporate them into its management information system to ensure current and reliable Member data.

- 3.5.3.1. Describe how the organization will receive, process, and integrate monthly enrollment rosters from the State into your management information systems.

3.5.4 Transitioning Members Between Dental Plans

Member transitions between Dental Plans may occur for a variety of reasons, including changes in enrollment, program participation, or provider network status. To ensure continuity of care and minimize disruption to services, the Contractor is expected to maintain written policies and procedures for the timely and efficient transfer of relevant patient information—including medical records, care plans, and other pertinent documentation—when a Member transitions to or from another Dental Plan or MCO. These processes support uninterrupted access to covered services, protect Member health and safety, and reduce the risk of avoidable hospitalization or institutionalization, particularly for Members with ongoing clinical needs. Transfers of required information must be completed at no cost to the Member, while any Member request for a personal copy of their medical record may be subject to reasonable fees consistent with Rhode Island Department of Health regulations.

- 3.5.4.1. Describe your organization's policies and procedures for transferring Member records—both clinical and administrative—when a Member transitions between dental plans, including expected timeframes and data formats. Explain how you will ensure that these transitions occur at no cost to the Member, including situations where Providers leave your network. Outline your transition of care policy to guarantee continued access to services during plan changes, including maintaining Provider continuity for up to 180 days. Additionally, describe how you will comply with requests for historical utilization data and facilitate referrals to appropriate network Providers during Member transitions

3.5.5 Member Disenrollment

Disenrollment is a critical program integrity and member protection function that must be administered consistently, equitably, and in accordance with State and federal requirements. To ensure uniform application of Medicaid eligibility rules and safeguard Member rights, the State retains sole authority for disenrolling Members from Dental Plans, and Contractors may not independently disenroll Members. Contractors play an essential support role by assisting Members with disenrollment requests—including providing translation services—and ensuring that disenrollment information and required forms are accessible through the Contractor's website and available by mail upon request. This approach promotes transparency, ensures timely and

appropriate processing of disenrollment actions for eligibility, relocation, just cause, and other permitted reasons, and reinforces protections prohibiting discriminatory or inappropriate disenrollment practices, consistent with applicable CMS requirements (including 42 CFR § 438.56³²).

3.5.5.1. Describe your organization’s process for assisting Members with disenrollment requests, including the provision of translation services and access to required forms. Outline your written policies and procedures for complying with State-issued disenrollment orders and explain how you will ensure adherence to federal and state regulations that prohibit disenrollment based on health status, service utilization, or Member behavior. Additionally, describe how you will support disenrollment requests related to access to related services as defined under 42 CFR § 438.56, and provide your procedures for communicating disenrollment effective dates to Members.

3.5.5.2. Reasons for Disenrollment
Include this information in response to 3.5.5.1.

3.5.5.3. Disenrollment Effective Dates
Include this information in response to 3.5.5.1.

3.6. In-Plan Services

The RIte Smiles 4-ALL program includes comprehensive dental benefit packages tailored to the needs of three (3) distinct Medicaid Member populations, with covered and non-covered services defined to support consistent access to appropriate care.

For Members under age twenty-one (21), dental services are governed by the federal EPSDT medical necessity standard and are designed to ensure early identification, treatment, and ongoing monitoring of dental conditions, including enhanced protections for children with complex needs or Special Health Care Needs.

Adult Members age twenty-one (21) and over receive access to a defined comprehensive dental benefit package that supports medically necessary care, while certain services may remain outside the plan and continue to be reimbursed through fee-for-service or the Member’s medical managed care benefit.

Adults with Special Health Care Needs require a benefit design that addresses more complex clinical and functional needs, ensuring access to essential covered services while coordinating out-of-plan benefits through existing Medicaid coverage pathways.

Members with complex dental and special health care needs may require comprehensive assessment, integrated care planning, and ongoing coordination across medical and dental systems to support access to services, continuity of care, and improved outcomes.

To maintain program responsiveness and fiscal sustainability, the State may adjust in-plan covered services and associated reimbursement arrangements over time through formal notice and contract amendment processes.

3.6.1 Description of Comprehensive Benefit Package

³² 42 CFR § 438.56 - <https://www.ecfr.gov/current/title-42/section-438.56>

- 3.6.1.1. Describe how your organization will provide the three required comprehensive dental benefit packages for children, adults, and adults with special health care needs. Explain how you will ensure that all covered services including diagnostic, preventive, restorative, and other procedures—are delivered in accordance with the requirements outlined in Attachment 1. Detail your policies and procedures for providing Members access to a second opinion at no cost and describe how you will coordinate Out-of-Plan benefits that are reimbursed either on a fee-for-service basis or through the Medical Managed Care benefit.
- 3.6.2 Medically Necessary Covered Dental Services
 - 3.6.2.1. Describe how your organization will ensure compliance with EPSDT requirements, including assessing and monitoring children with special health care needs, delivering services per the AAPD Periodicity Schedule and medical necessity standards, reviewing service requests and determinations, and ensuring all medically necessary Medicaid-covered services are provided and billed appropriately
- 3.6.3 Adult Members Ages Twenty-one (21) and Over
 - 3.6.3.1. Describe how your organization will provide the comprehensive adult benefit package and ensure medically necessary covered services are delivered. How will you coordinate Out-of-Plan adult dental benefits while complying with billing rules for medically necessary services not in the package.
- 3.6.4 Adults Members Ages Twenty-One (21) and Over with Special Health Care Needs
 - 3.6.4.1. Describe how your organization will ensure the delivery of essential dental benefits to adults with special health care needs, as defined in Article 1 and Attachment 1. Explain how your benefit package is designed to meet the unique diagnostic, preventive and restorative treatment needs of this population. Additionally, detail how you will coordinate with Medical Managed Care Organizations to support effective case management and care coordination for these Members.
- 3.6.5 Specialized Case Management Services
 - 3.6.5.1. Describe your organization’s process for conducting Initial Health Assessments (IHAs) and developing Integrated Health Care Plans (IHCPs) for children and adults with special health care needs. Explain how you will ensure that care coordination, case management, and follow-up treatment services outlined in IHCPs are delivered. Detail your procedures for annual reassessment and ongoing monitoring of Members with IHCPs, including how treatment needs are reassessed when Member circumstances change and how IHCP implementation is tracked over time
- 3.6.6 Changes to In-Plan Services
 - 3.6.6.1. Describe how your organization will respond to changes in covered in-plan services, including accepting or rejecting new service additions within required timelines. What process will you use to implement amendments related to in-

plan service changes and ensure alignment with updated capitation rates?

3.7. Care Coordination

3.7.1 General

Care coordination is a core program function designed to support integrated, member-centered care across dental, medical, behavioral health, and social support systems. Strong communication and timely information exchange among primary dental providers, specialists, and primary care medical providers is essential to ensure Members receive appropriate services in the right setting. The Initial Health Assessment (IHA) (42 CFR § 438.208 (c)(3)³³), establishes an early baseline of each new Member's demographic, medical, oral, behavioral, and social risk factors to support risk stratification and timely identification of service needs. This screening process strengthens the program's ability to assign appropriate levels of care coordination and case management and monitor outcomes in alignment with federal care management requirements.

Coordination with the Medical MCO ensures that medical, oral health, behavioral, and social service supports are aligned and that progress and outcomes are consistently tracked. The RI Integrated Health Care Plan (IHCP) supports coordinated, whole-person care by documenting Member needs and guiding service delivery across systems.

- 3.7.1.1. Describe the methodology the organization will use to comply with the Initial Health Assessment requirement for all RIte Smiles 4-ALL Members, including timing, methodology, and tools or systems used to ensure completion.

3.7.2 Care Coordination

Comprehensive care coordination is essential to ensuring continuity of care, effective transitions, and integration of services across multiple providers and settings. This approach promotes timely access to care, reduces barriers such as transportation and language needs, and supports ongoing outreach and follow-up for Members who may experience access challenges.

- 3.7.2.1. Explain your organization's procedures for facilitating and monitoring care coordination for all Members. Include processes for communication among Providers and coordination with other payers or health plans.

3.7.3 Case Management

Case management provides a structured method for supporting Members with complex needs by assigning responsibility for care coordination and ensuring access to medically necessary services both in and out of network. This includes proactive reminders, follow-up after missed visits or emergency care, and coordination across managed care, fee-for-service, and community-based supports to improve outcomes and reduce avoidable utilization.

- 3.7.3.1. Explain your organization's procedures for facilitating and monitoring individualized case management for high-risk qualifying Members, including children, adults, and adults with special health care needs. Include processes for communication among Providers and coordination with other payers or health plans.

³³ 42 CFR 438.208 (c)(3) - <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.208>

3.7.4 Disease Management

A comprehensive disease management program allows the Contractor to identify and support Members with chronic or high-risk conditions through targeted outreach, education, care planning, and monitoring. This function improves long-term outcomes by focusing resources on populations with the greatest need and addressing disparities identified through population-level assessment.

- 3.7.4.1. Describe your organization's comprehensive Disease Management Program, including methods for measuring outcomes, monitoring effectiveness, and reporting results.

3.7.5 Coordination of Pharmacy

Coordination of pharmacy services supports safe and timely access to medically necessary prescriptions by aligning efforts across providers and payers. Ensuring appropriate access to medications strengthens clinical outcomes and reduces service delays that may negatively impact Member health.

No response is required for this section.

3.7.6 Provider Advocacy Rights

Provider advocacy protections ensure that Members receive complete and unbiased information about their health status, treatment options, and care decisions. These protections reinforce Members' rights to participate in their care and support providers' ability to communicate openly in accordance with federal requirements.

No response is required for this section.

3.8. Provider Networks

3.8.1 Network Compositions

A strong, statewide provider network is essential to ensure Medicaid Members can access covered dental services in a timely manner, across geographic areas and levels of need. The program emphasizes adequate capacity across general and specialty dentistry, continuity of care for underserved populations, and ongoing network development to meet service accessibility standards.

- 3.8.1.1. Describe how the organization will establish and maintain a geographically accessible statewide Provider network of general and specialty dentists that meets accessibility standards and ensures timely access to services for children, adults, and adults with Special Health Care Needs, including those with developmental disabilities.

3.8.2 Transitioning Between Non-Network and Network Providers

Member transitions between plans or providers can create risks to continuity of care, particularly when medically necessary treatment is already underway. Clear transition processes support uninterrupted services by enabling temporary access to non-network providers while Members are connected to in-network care.

- 3.8.2.1. Fully explain the organization's policies and procedures for ensuring continuity of care when Members require services from non-network Providers, including transition visits, payment coordination, and financial protections for Members.

3.8.3 FQHCs/RHCs with Dental Clinics

FQHCs and RHCs play a critical role in serving Medicaid populations, particularly in high-need or underserved communities. Their inclusion supports network stability, access, and alignment with established safety-net delivery systems.

- 3.8.3.1. Provide a detailed explanation of how the organization will ensure the ongoing inclusion of adequate specialty Providers (e.g., endodontists, periodontists, prosthodontists, oral surgeons, orthodontists, dental anesthesiologists, and Public Health Dental Hygienists), as well as Providers who work in non-traditional settings such as hospitals, school-based, community-based, mobile/portable, and teledental care, to meet the oral health needs of underserved populations.

3.8.4 Hospital-Based Dental Clinics

Hospital-based dental clinics provide specialized services and are an important access point for medically complex Members who may require higher-acuity care. Network inclusion strengthens care pathways for Members who need coordinated clinical support.

No response is required for this section.

3.8.5 School-Based and School-Linked Dental Providers

School-based and school-linked providers expand preventive and routine dental access for children by bringing services closer to where families already engage. These models help reduce missed appointments, improve early intervention, and support equitable access for Medicaid-enrolled students.

No response is required for this section.

3.8.6 Mobile and Portable Dental Providers

Mobile and portable dental delivery models increase access for Members who face transportation, geographic, or functional barriers to care. Including these providers supports broader statewide reach and helps address disparities in oral health service utilization.

No response is required for this section.

3.8.7 Mainstreaming

Mainstreaming is a program priority that promotes equal access to care by integrating Medicaid Members into the broader healthcare delivery system without segregation or differential treatment. This approach reinforces fairness, supports dignity, and strengthens provider accountability across the network.

No response is required for this section.

3.8.8 Provider Directory

Accurate, accessible provider directories are essential tools for Members to locate appropriate in-network care and understand provider capabilities. Regular updates support informed Member choice and improve access by ensuring information is current, complete, and available in both electronic and paper formats.

- 3.8.8.1. Describe how your organization will maintain and update a comprehensive

Provider directory—both electronic and paper formats—that include Provider specialties, acceptance of new Members, cultural and linguistic capabilities, and physical accessibility accommodations, and how the Bidder will ensure this directory is accurate, timely, and accessible.

3.8.9 Network Changes

Provider networks must remain stable, adequate, and responsive over time to ensure Members maintain timely statewide access to covered services. Ongoing network monitoring and quarterly reporting support EOHHS oversight and early identification of significant changes that may affect capacity, access, benefits, service area, or provider participation. Clear communication requirements—including Member notification and provider termination notices—help protect continuity of care and support informed Member choice.

- 3.8.9.1. Explain how the organization will monitor network changes, including anticipated Provider terminations or additions, and describe the procedures for notifying EOHHS and Members of significant changes to network capacity, composition, or accessibility.

3.8.10 Provider Discrimination

Non-discriminatory provider participation policies are essential to maintaining a fair and inclusive network and ensuring compliance with federal managed care requirements. Prohibiting discrimination against providers acting within their lawful scope of practice supports network diversity, strengthens access, and ensures the provider workforce can effectively meet the needs of the Medicaid population.

- 3.8.10.1. Describe the organization's written policies and procedures for Provider selection, credentialing, and re-credentialing, including how the Contractor ensures compliance with 42 CFR §438.214³⁴, does not discriminate against Providers serving high-risk populations, and does not contract with Providers excluded from federal health care programs.

3.8.11 Indian Health Care Provider (IHCP)

Federal requirements ensure that Indian Health Care Providers are reimbursed appropriately for covered services delivered to eligible Members, regardless of whether the IHCP is enrolled as an FQHC or participates in the Contractor's network. These protections preserve access to care through Indian health systems and ensure consistent payment methodologies aligned with applicable encounter rates or State plan fee-for-service reimbursement.

- 3.8.11.1. Describe how the organization will ensure timely access to services from Indian Health Care Providers (IHCP) and I/T/U Providers, including network inclusion, capacity assessment, Member choice, and compliance with applicable federal payment requirements.

3.8.12 Networks Related to Native Americans

- 3.8.12.1. Native American Members must be permitted to access covered services

³⁴ 42 CFR §438.214 - <https://www.ecfr.gov/current/title-42/section-438.214>

through participating Indian Tribes, Tribal Organizations, and Urban Indian Organizations (I/T/U), including the ability to select an eligible I/T/U provider when capacity allows. Ensuring a sufficient network of I/T/U providers supports timely access to culturally appropriate care and continuity of services. Payment and prompt reimbursement requirements further ensure equitable treatment of I/T/U providers and support the sustainability of services delivered to eligible Native American Members within managed care arrangements.

No response is required for this section.

3.8.13 Network Provider Credentials and Agreements

Provider screening, enrollment, and credentialing safeguards program integrity and Member safety by ensuring that network Providers meet State and federal requirements and are qualified to deliver covered services. Uniform credentialing and re-credentialing processes aligned with State regulations and recognized accreditation standards promote consistency and accountability across the provider network. Timely reporting of provider denials, suspensions, or participation limitations related to quality or program integrity strengthens transparency and supports effective EOHHS oversight.

No response is required for this section.

3.8.14 Telehealth / Teledental

Telehealth and teledental capabilities expand access to care, improve service responsiveness, and reduce barriers for Members who may experience geographic or logistical challenges. A structured telehealth/teledental program supports patient education, care monitoring, and appropriate clinical interventions while ensuring services are delivered in compliance with Rhode Island laws and applicable professional standards.

- 3.8.14.1. Describe your organization's Telehealth/Teledental Program, including covered services, patient education, medication and equipment management, monitoring of patient conditions, and how the program ensures compliance with applicable Rhode Island laws and regulations.

3.9. Service Accessibility Standards

3.9.1 Urgent Dental Condition Standard

Timely access to urgent dental care is essential to prevent worsening conditions and reduce avoidable emergency service use. Clear member and provider guidance, supported by written procedures and ongoing communications, helps ensure urgent needs are addressed promptly while reinforcing the distinction between in-plan urgent dental services and out-of-plan emergency benefits.

- 3.9.1.1. Describe the organization's policies and procedures that ensure compliance with accessibility standards, including appointment availability, waiting times, timely access, telephone access, and specialty dental services.

3.9.2 Travel Time

Geographic access standards help ensure Members can obtain dental services within reasonable travel time and distance based on age and provider type. Consistent network adequacy

requirements support equitable statewide access, allow appropriate flexibility in provider selection, and provide a structured process for exceptions and ongoing monitoring when access limitations occur.

Include this information in response to 3.9.1.1.

3.9.3 Days to Appointment for Non-Emergent Conditions

Defined appointment scheduling standards ensure Members can access routine and preventive dental care within reasonable timeframes, including timely access for newly enrolled Members. These expectations support early intervention, continuity of care, and Member choice among providers accepting new patients.

- 3.9.3.1. Fully explain the organization's approach to monitoring network capacity and compliance with network adequacy standards. Include methods for identifying and resolving gaps where required timeframes or distance standards are not met.

3.9.4 Compliance with Accessibility Standards

Ongoing provider monitoring and corrective action processes are necessary to ensure network compliance with service accessibility standards. Strong oversight promotes consistent access, timely care delivery, and accountability across the provider network.

Include this information in response to 3.9.1.1.

3.10. Marketing

3.10.1 General Provisions

Marketing and member communications play a critical role in supporting informed choice and ensuring Members receive accurate program information. To protect Members and maintain program integrity, all marketing activities must align with State and federal requirements and follow EOHHS-established review and approval processes.

- 3.10.1.1. Describe your organization's policies and procedures for ensuring compliance with all applicable federal and state marketing requirements, including oversight of subcontractors and representatives, and the process for obtaining prior approval from EOHHS for all marketing materials and activities. Provide a copy of the RItE Smiles 4-ALL Marketing Plan your organization proposes to use, including procedures for updates and amendments.

3.10.2 Marketing Multiple Lines of Business

Clear separation between Medicaid managed care marketing and other business lines helps prevent confusion and protects Members from inappropriate influence or steering. Opt-out protections and distinct messaging support transparency and ensure Members are not targeted for non-Medicaid products through Medicaid-related outreach.

Include this information in response to 3.10.1.1.

3.10.3 Allowable Marketing Activities

Allowable marketing activities are intended to support community education and respond to Member and potential Member questions while maintaining fairness and compliance. Structured oversight and standardized training for marketing representatives help ensure outreach is accurate,

non-discriminatory, and consistent with Medicaid program goals.

- 3.10.3.1. Describe the marketing activities to be utilized by your organization and its representatives (e.g., community events, sponsorships, mass media) and detail the training and monitoring processes that will be implemented to ensure marketing representatives and Providers comply with all applicable state and federal requirements and conduct such activities in a non-discriminatory and compliant manner.

3.10.4 Marketing Activities by Providers

Providers are often a trusted source of information for Members, making provider-related marketing oversight essential to maintaining neutrality and protecting Member choice. Clear guidance ensures providers can share information without influencing plan selection or participating in prohibited enrollment activity.

- 3.10.4.1. Describe the guidance and training your organization will make available to network Providers regarding allowable and prohibited marketing activities and detail the mechanisms your organization will implement to monitor and enforce Provider compliance, including ensuring that Providers do not engage in steering Members toward a specific dental plan or distributing unapproved materials.

3.10.5 Prohibited Statements and Claims

Restrictions on misleading statements safeguard Members from misinformation and prevent marketing practices that improperly imply government endorsement or guaranteed benefits. These limits reinforce ethical marketing standards and help maintain trust in the Medicaid program.

- 3.10.5.1. Describe the measures and procedures your organization and representatives will implement to prevent prohibited marketing statements and activities, including, but not limited to, misleading claims, implied government endorsements, enrollment tied to benefits, cold calling, unsolicited contacts, door-to-door marketing, and marketing near restricted locations. Also, describe the procedures your organization will use to ensure that social media interactions are not construed as ongoing consent for contact.

3.10.6 Prohibited Activities

Limits on cold-call outreach, inducements, and marketing in sensitive locations are designed to prevent coercive or inappropriate enrollment practices. These safeguards help ensure marketing is respectful, Member-driven, and free from pressure or undue influence.

Include this information in response to 3.10.5.1.

3.10.7 Marketing Materials

Marketing materials must be clear, accessible, and culturally and linguistically appropriate so Members can understand their options and benefits. Standard formatting, disability accommodations, and required review processes support consistent statewide messaging and protect against discriminatory or misleading content.

- 3.10.7.1. Provide a full and complete description of the processes your organization will

implement to ensure that all websites, social media, and electronic posts comply with state and federal requirements as outlined in the model contract and are submitted for prior EOHHS approval.

3.10.8 Remedial Actions for Marketing Violations

Defined corrective actions and enforcement tools help EOHHS respond promptly to marketing non-compliance and protect affected Members. These remedies support accountability and provide a structured approach for addressing violations, preventing recurrence, and preserving program integrity.

- 3.10.8.1. Explain in full the internal processes that your organization will implement to identify, report, and correct marketing violations, including how the Bidder will respond to EOHHS remedial actions, including recalling materials, suspending enrollment, or notifying Members of non-compliance.

3.11. Member Services

3.11.1 General

A responsive Member Services function is essential to ensuring Members can obtain timely support, understand their benefits, and navigate access to care. Standard hours of operation, clear procedures, and adequate staffing help ensure consistent assistance aligned with State operations and Member needs.

- 3.11.1.1. Describe in detail the organization's Member Services function, including staffing model, training, and protocols to ensure timely and adequate responses during required hours. Include a flow chart that depicts effective triage and care coordination. Describe procedures for handling emergency/urgent dental needs, care coordination, complaints, and non-emergency transportation in coordination with the State's broker. Explain how a toll-free line with TDD/TTY and foreign language interpretation services will be maintained.

3.11.2 Toll-Free Telephone Number

A toll-free telephone line strengthens access by providing Members a reliable point of contact for assistance without financial barriers. Access to TTY/TDD and interpretation services supports effective communication and ensures Members with disabilities or Limited English Proficiency can receive support equitably.

Include this information in response to 3.11.1.1.

3.11.3 Annual Notification

Annual Member notices promote transparency by ensuring Members are regularly informed of key plan information, rights, and available benefits. These communications support informed decision-making and reinforce awareness of provider access, grievance and appeal options, and emergency service procedures.

Include this information in response to 3.11.1.1.

3.11.4 Cultural Competency

Culturally competent service delivery improves equity and health outcomes by ensuring care and communications are responsive to Members' linguistic, cultural, and accessibility needs. Training,

language supports, and targeted initiatives help reduce barriers and strengthen engagement across diverse populations.

- 3.11.4.1. Describe how the organization will ensure culturally and linguistically appropriate services across all Member interactions, including staff and Provider training, interpreter/translation services, thresholds for written translations, in-person language assistance, and designation of language capabilities in Provider directories.

3.11.5 Transportation

Reliable transportation is a critical access support for Members who may otherwise be unable to attend dental appointments. Coordination with the State's centralized non-emergency transportation system helps ensure Members can reach covered services when transportation is a barrier.

Include this information in response to 3.11.4.1.

3.11.6 Interpretation and Translation Services

Language access services are vital to ensuring Members can understand benefits, communicate with providers, and receive timely care. Translation and interpretation requirements support meaningful access for non-English speakers and reinforce compliance with ADA communication standards for Members with disabilities.

Include this information in response to 3.11.4.1.

3.11.7 Services for New Members

Immediate access to benefits upon enrollment supports early engagement in care and reduces delays in medically necessary services. This expectation reinforces continuity of coverage and ensures new Members can begin using services without interruption.

Include this information in response to 3.11.1.1.

3.11.8 New Member Orientation

New Member orientation helps Members understand how to use their benefits, access providers, and navigate grievances and supports. Clear, easy-to-understand materials and structured welcome outreach strengthen engagement while ensuring communications reflect cultural, linguistic, and accessibility needs.

- 3.11.8.1. Describe how the organization will ensure that all new Members have immediate access to the full scope of dental benefits upon enrollment. Include policies and processes for new Member orientation, welcome calls, distribution of permanent identification cards, and accessibility of materials in alternative formats and languages.

3.11.9 Identification Cards

Member identification cards support smooth access to covered services and help Members quickly connect with urgent support and plan resources. Timely issuance of cards reduces administrative barriers and reinforces program consistency for newly enrolled Members.

Include this information in response to 3.11.8.1.

3.11.10 Members Handbook

The Member Handbook serves as a primary reference tool for benefit information, rights, and plan procedures. Using an EOHHS model handbook and maintaining accessible formats ensures consistent statewide messaging and supports Member understanding across literacy and language needs.

- 3.11.10.1. Fully describe the organization's policies and procedures for the development, review, approval, distribution, and ongoing maintenance of all Member-facing materials, including the Model Member Handbook, Member packets, and required notifications (42 CFR §438.100³⁵ and §438.10³⁶). Include processes for ensuring cultural and linguistic appropriateness, interpreter /translation services, ADA compliance, and submission of materials to EOHHS for approval and modifications as directed.

3.11.11 Required Information

Standardized content requirements ensure that Members receive complete and accurate information about benefits, provider access, rights, and program processes. Clearly defined required elements promote informed choice, support program compliance, and strengthen Member protections.

Include this information in response to 3.11.10.1.

3.11.12 State Approval

State review and approval of Member materials ensures consistency, accuracy, and compliance with Medicaid requirements. This process protects Members by preventing dissemination of incorrect or incomplete information and supports statewide program integrity.

- 3.11.12.1. Provide a statement of understanding and intent to comply.

3.11.13 Languages other than English

Providing materials in multiple languages supports equitable access for Members with Limited English Proficiency and improves the usability of plan information. Language-based distribution requirements ensure critical materials are available and updated based on the Contractor's enrolled population.

Include this information in response to 3.11.12.1.

3.12. Provider Services

3.12.1 General

A strong Provider Services function supports network stability, consistent program operations, and timely access to care by ensuring Providers receive responsive assistance, clear guidance, and ongoing education. Standardized provider communications, training, and performance expectations help align Providers with RItE Smiles 4-ALL benefit requirements, reporting standards, and member-focused service delivery.

- 3.12.1.1. Describe your organization's overall approach to establishing and monitoring

³⁵ 42 CFR §438.100 - <https://www.ecfr.gov/current/title-42/section-438.100>

³⁶ 42 CFR §438.10 - <https://www.ecfr.gov/current/title-42/section-438.10>

Provider service performance standards, including methods for ongoing communication, evaluation, education, onboarding, and training.

- 3.12.1.2. Describe Provider training process to ensure competency and accuracy in the submission of ICD-10 dental codes with claims submission.

3.13. Quality Assessment and Performance Improvement (QAPI)

3.13.1 General Requirements (QAPI Program)

A comprehensive Quality Assessment and Performance Improvement (QAPI) program is essential to ensure services are safe, effective, equitable, and continuously improving across all covered populations. Alignment with NCQA standards and the State's Medicaid Managed Care Quality Strategy ensures the Contractor's quality framework supports statewide priorities, including improved oral health access, value-based care, and targeted improvements for Members with Special Health Care Needs.

- 3.13.1.1. Describe the structure, governance, and oversight of your Quality Assessment and Performance Improvement (QAPI) program, including compliance with NCQA standards, federal requirements, and Rhode Island regulations. Explain how you ensure that development and oversight of QAPI are not delegated, and how any delegated quality functions are managed in accordance with state and NCQA delegation standards.
- 3.13.1.2. Explain how your QAPI and Quality Management/Improvement (QM/QI) programs align with Rhode Island's Medicaid Managed Care Quality Strategy and EOHHS priorities, including advancing health access, equity, value-based care, and continuous quality improvement.
- 3.13.1.3. Describe how your organization designs, implements, and monitors Performance Improvement Projects (PIPs) and other interventions to improve care. Include how you incorporate population-specific strategies, such as those for Members with Special Health Care Needs (SHCN), and how you evaluate and improve internal processes to address disparities and enhance outcomes.
- 3.13.1.4. Explain your approach to ensuring quality of care across the following domains: clinical quality of oral health services, access and availability of Providers, continuity and coordination of care, appropriateness of care for Members at risk for disparities, and Member experience. Provide the mechanisms you will use to measure, monitor, and improve performance in these areas.
- 3.13.1.5. Describe how your organization applies the principles of Continuous Quality Improvement (CQI) across all aspects of its service delivery system, including the use of quantitative and qualitative data collection; the development, adoption, and periodic review of evidence-based practice guidelines; the integration of such guidelines with Utilization Management, Member education, coverage of services, and other areas of care delivery; and issues identified by EOHHS and contractual QAPI requirements into the design, planning, and implementation of CQI activities, particularly as they relate to oral health services.

3.13.2 Quality Measurement

Standardized quality measurement enables the State and Contractor to monitor performance, identify disparities, and track progress across key outcomes and access indicators. Stratified data collection supports more accurate evaluation of quality and equity across Member populations and provider networks.

- 3.13.2.1. Describe how your organization will collect and report data on quality measures to EOHHS, including the ability to stratify results by age, race, ethnicity, language, disability, and any other characteristics specified by EOHHS. Include how your systems will adapt to additional guidance provided by EOHHS regarding the scope and format of data collection.
- 3.13.2.2. Explain how you will ensure that Accountable Entities and Providers collect and report quality measure data in a way that captures and stratifies Member demographics and other characteristics specified by EOHHS. Describe the infrastructure, oversight processes, and validation methods you will use to guarantee accuracy, timeliness, and completeness of reporting.

3.13.3 Quality Reporting

Routine reporting of quality measures provides visibility into Contractor performance and supports contract oversight and continuous improvement. Defined reporting schedules and standardized measures ensure consistent accountability and comparability across vendors.

- 3.13.3.1. Describe how your organization will measure and report performance using the standard quality measures required by EOHHS, and how you will ensure timely submission of data according to the schedule outlined in the Dental Managed Care Manual.

3.13.4 QAPI Program Basic Elements

Foundational QAPI elements ensure the Contractor has structured methods for collecting data, identifying overuse and underuse, assessing care appropriateness, implementing interventions, and evaluating results. These program components support evidence-based improvement and sustained progress in both clinical and operational performance areas.

- 3.13.4.1. Describe how your QAPI Program will be tailored to the Dental Managed Care Program requirements, guided by current NCQA Health Plan Accreditation standards and guidelines, and aligned with your organization's Health Access and Utilization Management strategies as required under Section 13.2. Include the required QAPI program structure.

3.13.5 QAPI Program Structure

A clearly defined QAPI governance structure strengthens accountability by establishing roles, responsibilities, and executive oversight for quality performance. Organization-wide implementation ensures quality improvement efforts are coordinated across departments, providers, and subcontractors.

Include this information in response to 3.13.4.1.

3.13.6 Quality Management/Quality Improvement (QM/QI) Committee

A dedicated QM/QI Committee supports structured oversight of the quality program by guiding strategy, monitoring results, setting benchmarks, and ensuring follow-through on improvement initiatives. Regular meetings and documented decisions help maintain transparency and demonstrate compliance with State and accreditation expectations.

- 3.13.6.1. Describe the structure of your QM/QI Committee, including required Membership such as the Dental Director (as chairperson) and Health Access Officer, and explain how the Committee ensures appropriate expertise and leadership to oversee successful QAPI programs.
- 3.13.6.2. Explain how your QM/QI Committee will oversee the development, review, and approval of the QAPI program description, key performance indicators, dental PIPs, annual work plans, and annual evaluations. Include how benchmarks will be set, performance goals established, and quality improvement activities implemented across the organization.
- 3.13.6.3. Describe how your QM/QI Committee will involve subcontractors and Network Providers in quality improvement activities, monitor and evaluate QM/QI results, direct task forces or subcommittees, and ensure corrective actions and follow-up occur.
- 3.13.6.4. Explain how your QM/QI Committee will review Provider performance, analyze Member service utilization patterns, designate study/evaluation procedures, and ensure timely reporting of progress, study results, and mandatory measures (e.g., HEDIS®-like) to leadership, subcontractors, Providers, and EOHHS.
- 3.13.6.5. Describe how your QM/QI Committee will meet and maintain compliance with meeting requirements, including holding meetings at least quarterly, maintaining comprehensive and accurate records through written minutes and enhanced note-taking technologies, ensuring records capture substantive discussions and action items, securely storing and submitting finalized minutes and supplemental media to EOHHS within required timeframes, making signed and dated minutes available for review during accreditation or audits, and providing the EOHHS Dental Director advance notice of meetings with the option to attend.

3.13.7 Performance Improvement Projects (PIPs)

Performance Improvement Projects provide a focused approach to achieving measurable improvements in clinical outcomes, access, and Member experience. Requiring both clinical and non-clinical PIPs ensures the Contractor addresses high-impact service delivery priorities and produces annual evidence of meaningful progress.

- 3.13.7.1. Describe how your organization will design and implement at least two (2) Dental Performance Improvement Projects (PIPs) annually, addressing both clinical and non-clinical topics. Include how PIP topics will be selected, how you will incorporate measures or topics required by EOHHS, CMS, or other stakeholders, and how Contractor-initiated PIPs will be submitted for approval.
- 3.13.7.2. Explain how you will ensure all PIPs comply with CMS protocols (42 CFR §

438.330³⁷), including documentation of all required steps, identification of benchmarks, establishment of achievable performance goals, and development of key performance indicators (KPIs). Describe the strategies you will use to implement interventions, promote sustained improvements, and achieve measurable outcomes in oral health and Member satisfaction.

- 3.13.7.3. Describe how your organization will monitor and evaluate the effectiveness of each PIP, ensure results can be validated by EOHHS or its designee, and report status and outcomes within required timeframes. Include how progress will be reported to the QM/QI Committee and EOHHS, how ongoing projects extending beyond one year will be documented through annual reports, and how aggregate results will inform continuous improvement in quality of care.

3.13.8 Written Work Plan

A written QAPI program description and annual work plan establishes a clear roadmap for quality priorities, performance goals, and planned interventions. This structured planning supports readiness, ongoing oversight, and alignment of staff and provider participation in improvement activities.

- 3.13.8.1. Describe your organization's written QAPI Program, including its organizational structure, processes, and Annual Work Plan. Explain how performance goals, objectives, KPIs, and quality improvement activities are identified, documented, and submitted during Readiness Review, annually thereafter, and upon modification.
- 3.13.8.2. Describe how your Annual Work Plan reflects a coordinated strategy to implement the QAPI Program, including planning, decision-making, interventions, and assessment of results. In your response, include how you evaluate the impact and effectiveness of the QAPI Program; describe the staffing, organization, training, and responsibilities of staff assigned to the QAPI Program; outline how Providers give input; ensure the Work Plan is specific to the RItE Smiles 4-ALL Program; and describe the methods used to ensure data reported to EOHHS is valid, accurate, and reflects adherence to clinical practice guidelines.

3.13.9 QAPI Reporting

Comprehensive QAPI reporting supports continuous monitoring of quality outcomes, Member experience, disparities, and performance improvement results. Regular submission of standardized measures and program evaluations ensures EOHHS can track progress and identify areas requiring further action.

- 3.13.9.1. Describe how your organization will measure and report its performance in accordance with the standards, reporting formats, and timetables established by EOHHS and outlined in the Medicaid Managed Care Manual. In your response, include how you will report annually on EOHHS-specified KPIs and Pay for

³⁷ 42 CFR § 438.330 - <https://www.ecfr.gov/current/title-42/section-438.330>

Performance measures, CMS-specified KPIs (including Child and Adult Core Dental Measures), HEDIS®-like dental measures, oral health disparity results (using ICD-10 and CDT codes), CAHPS® results, PIP results, recommended new or improved quality improvement activities, and the evaluation of the impact and effectiveness of the QAPI Program. Also describe how you will respond to requests for additional reports from EOHHS, including ad-hoc reports and reports for special populations, using EOHHS-approved specifications, formats, and reporting timelines.

3.13.10 Evaluation

Annual evaluation of the QAPI program ensures improvement activities remain effective, targeted, and responsive to program needs. Reviewing KPI results, core measures, and stratified outcomes supports data-driven refinement of quality priorities and future work planning.

- 3.13.10.1. Describe how your organization will conduct an annual evaluation of the QAPI Program, inclusive of Performance Improvement Projects (PIPs), to inform the written work plan and any updates to the QAPI Program. In your response, explain how you will stratify program results to assess equity and access outcomes across different population groups.

3.13.11 Additional Quality Assurance Reporting Requirements

Additional reporting and medical record review requirements support independent validation and deeper analysis of care quality across key populations. These activities strengthen program oversight and provide supporting evidence for external quality review processes.

- 3.13.11.1. Describe how your organization will make internal quality assurance reports available to EOHHS upon request, and how you will ensure timely submission of results from quality improvement studies or projects no later than thirty (30) days after presentation to your QM/QI Committee.
- 3.13.11.2. Describe your organization's process for performing medical record abstractions in selected quality assurance areas for use in external quality reviews. In your response, include how you will provide at least three selected quality assurance areas for RItE Smiles 4-ALL (one related to EPSDT, one for adults 21 and over, and one for adults 21 and over with Special Health Care Needs), how you will respond to additional requests from EOHHS, and how you will work cooperatively with EOHHS to implement methodologies provided.

3.13.12 Reporting, Accuracy, Completeness and Timeliness

Accurate and timely reporting is critical to maintaining reliable oversight and ensuring performance results reflect actual service delivery and outcomes. Strong validation processes support integrity in quality measurement and reinforce accountability for improvement.

- 3.13.12.1. Describe how your organization will ensure that all performance measures reported are accurate, complete, and timely; how you will cooperate fully with EOHHS or its designees in validating PIPs and quality reporting; and how you will participate in joint quality improvement projects with EOHHS, and other

Health Plans as required.

3.13.13 Member Satisfaction

Member satisfaction measurement provides insight into service experience, access barriers, and perceived quality of care. Annual surveys help ensure the program remains responsive to Member needs and supports improvement in engagement and outcomes.

- 3.13.13.1. Describe how your organization will collect Member satisfaction data for adults, children, and other populations or sub-populations as identified by EOHHS through an annual survey of a representative sample of Members, using a tool approved by EOHHS. In your response, explain how survey administration, sampling, and reporting will ensure valid, reliable, and actionable results.

3.13.14 Provider Satisfaction

Provider satisfaction data helps identify administrative, operational, and network issues that affect participation and service delivery. Independent surveys support objective feedback and inform improvements that strengthen provider engagement and network stability.

- 3.13.14.1. Describe how your organization will employ an External Quality Review Organization (EQRO) to collect Provider satisfaction data through an annual survey of a representative sample of your Providers. In your response, explain how the EQRO will be engaged, how survey tools will be approved by EOHHS, and how results will be reported and used for quality improvement.

3.13.15 Mandatory Meetings

Regular oversight meetings support active contract monitoring and provide a structured forum to review performance, compliance trends, and quality outcomes. Ongoing collaboration supports timely issue resolution and continuous improvement.

- 3.13.15.1. Provide a statement of understanding and intent to comply.

3.13.16 Clinical Data Exchange

Timely clinical data exchange supports accurate quality reporting and improves the Contractor's ability to manage performance on standardized measures. Use of a State-approved vendor strengthens consistency and supports statewide reporting needs.

- 3.13.16.1. Describe how your organization will contract with a state-approved vendor to ensure the appropriate and timely exchange of clinical data related to quality performance (e.g., HEDIS®). In your response, explain how you will ensure accuracy, compliance with state requirements, and timely submission of data.

3.13.17 External Quality Review

Independent external quality review ensures accountability for access, quality, and timeliness of services delivered under the contract. Cooperation with EQRO activities supports transparency, validation of performance improvement efforts, and compliance with federal Medicaid managed care oversight requirements.

- 3.13.17.1. Describe how your organization will comply with annual external independent reviews of quality, timeliness, and access to services, and how you will support

external validation of performance improvement projects. In your response, explain how you will cooperate fully with EOHHS and its designated EQRO, including compliance with data requests and participation in access-related focused studies.

3.13.18 Key Performance Indicators (KPIs)

Key Performance Indicators provide a standardized framework for monitoring plan performance and linking financial incentives to quality outcomes. KPI benchmarks support accountability, promote continuous improvement, and help ensure capitation payments align with measurable results and State priorities.

- 3.13.18.1. Describe how your organization will measure, monitor, and report on the Key Performance Indicators (KPIs) and quality performance measures required under this contract, as outlined in the QAPI framework. (Attachment 7) In your response, explain how you will collect and report data on EPSDT program measures for children (including oral evaluations, topical fluoride applications, and dental sealant utilization across multiple age groups, as well as findings, and operating room/ambulatory surgical center utilization); Adult program measures (including preventive dental services, and oral evaluations during pregnancy); and Adult Special Health Care Needs (SHCN) measures (including preventive services, operating room utilization, and ambulatory surgical center utilization). Include your approach for establishing baselines, benchmarks, methodologies, and potential PIPs, ensuring valid, accurate, and timely reporting to EOHHS in compliance with contract requirements.

3.14. Utilization Management

3.14.1 General Requirements

A structured Utilization Management (UM) framework supports appropriate use of covered services while promoting high-quality, cost-effective care. Written UM policies aligned with NCQA standards and subject to EOHHS review help ensure consistent decision-making, confidentiality protections, program integrity reporting, and proper documentation and record retention.

- 3.14.1.1. Describe your organization's Utilization Management (UM) program for all Covered Services. How does the program facilitate delivery of high-quality, cost-efficient, and effective care, and how does it align with NCQ NCQA standards?
- 3.14.1.2. Explain your process for submitting written UM policies to EOHHS for approval during Readiness Review and prior to any substantive changes.
- 3.14.1.3. Outline your process for identifying, documenting, and reporting Fraud and Abuse information through the UM program in compliance with 42 CFR § 455.1(a)(1)³⁸.

3.14.2 Utilization Management Program and Plan

³⁸ 42 CFR § 455.1(a)(1) - <https://www.ecfr.gov/current/title-42/section-455.1>

A clearly defined UM Program Plan establishes the criteria, processes, and organizational structure used to review and authorize services in a fair, consistent, and clinically appropriate manner. Standardized review protocols, mechanisms to detect over- and under-utilization, and continuity-of-care provisions help ensure UM activities support Member access and reflect Medical Necessity and conflict-free decision-making standards.

- 3.14.2.1. Describe the processes your organization uses to review and authorize initial and continuing requests for services, including how modifications, denials, and behavioral health treatment monitoring are handled.
- 3.14.2.2. Explain how you train, supervise, and support UM clinical staff to ensure consistent application of medical necessity criteria and appropriate utilization of specialty services.
- 3.14.2.3. Describe your process for ensuring continuity of care for new Members when assuming responsibility for prior authorizations. How do you ensure that authorization decisions.
- 3.14.2.4. Explain the processes you use to monitor over- and under-utilization utilization, generate Provider utilization profiles, evaluate new dental technologies, and assess the effectiveness of your UM Program on an ongoing basis.

3.14.3 UM Program Structure

Effective UM operations require qualified, appropriately licensed clinical leadership and sufficient specialty expertise to support timely authorization decisions. Defined staffing standards and on-call clinical availability strengthen responsiveness, support clinical consultation, and ensure UM determinations are made by professionals with relevant expertise.

- 3.14.3.1. Describe how your organization's Dental Director and designated licensed dentist(s) will oversee and support the Utilization Management (UM) Program.
- 3.14.3.2. Describe how your organization ensures that UM staffing includes representatives from appropriate specialty areas (e.g., pediatric dentistry, oral surgery, orthodontics, endodontics, and other areas) to meet the needs of Members.
- 3.14.3.3. Describe your procedures for verifying that UM staff are in full compliance with federal, state, and local professional licensing requirements and have no history of disciplinary actions or legal sanctions, unless otherwise agreed to by Medicare and EOHHS.

3.14.4 QM/QI Committee Responsibilities (UM Oversight)

Integrating UM oversight into the QM/QI governance structure promotes alignment between utilization decisions, quality goals, and evolving clinical criteria. Committee review and monitoring help ensure UM policies remain current, consistently applied, and focused on appropriateness of care and access impacts.

- 3.14.4.1. Describe how the UM will comply with the responsibilities of the Quality Improvement Committee (QM/QI).

3.14.5 UM Program Monitoring

Ongoing monitoring of UM timeliness, consistency, and access impact helps identify administrative barriers and ensures prior authorization processes do not unreasonably limit medically necessary care. Incorporating provider feedback supports standardization and streamlining efforts that reduce burden while maintaining program safeguards.

- 3.14.5.1. Describe how your organization conducts ongoing monitoring and oversight of its Utilization Management (UM) Program and the process used to update the program when deficiencies are identified.
- 3.14.5.2. Explain the methods your organization uses to review timeliness and consistency of service authorizations, assess whether Prior Authorization procedures limit Member access, determine when Prior Authorization remains necessary, and incorporate Provider feedback to streamline and reduce administrative burden.

3.14.6 Standard Authorization Decisions

Standard and expedited authorization timeframes ensure Members receive decisions within clinically appropriate windows while maintaining procedural protections. Clear processes for extensions, consultation, 24/7 access for urgent needs, and NCQA-aligned denial procedures reinforce fairness, transparency, and timely access to medically necessary services.

- 3.14.6.1. Describe your process for making and providing notice of standard service authorization decisions, including how you ensure decisions are issued within 14 days, how extensions are requested or justified, and how Members and Providers are notified in a timely manner.
- 3.14.6.2. Explain how your organization processes requests for initial and continuing authorizations of Covered Services, including how Members may initiate requests, how review criteria are applied consistently, how CFCM requirements are incorporated, and how consultation with requesting Providers occurs when appropriate.
- 3.14.6.3. Describe your procedures for ensuring timely access to Medically Necessary Services 24/7, including emergency dental conditions that require transfer after stabilization, compliance with NCQA denial standards, and expedited authorization decisions within 72 hours when a Member's life, health, or function would be seriously jeopardized.

3.14.7 Denials for Out-of-Network Services

Formal notice requirements for out-of-network denials support transparency and ensure Members and providers receive clear communication when transition-of-care periods end. These protections help manage continuity expectations and align service decisions with documented authorization requirements.

- 3.14.7.1. Describe your organization's process for issuing formal written notices to Members, their Authorized Representatives, and Providers when denying Out-of-Network services delivered more than six (6) months after a Member's enrollment, in cases where no existing Prior Authorization requires extension of the transition of care period.

3.14.8 Compensation Arrangements

UM compensation structures must avoid incentives that could inappropriately influence service denials or reductions. Demonstrating neutral compensation safeguards clinical objectivity and supports Member-centered decision-making.

No response is required for this section.

3.14.9 Services Requiring Prior Authorizations

Clear, accessible notifications for prior authorization decisions—including adverse benefit determinations—support Member understanding and protect due process. Accessibility requirements ensure notices are usable for individuals with disabilities and Limited English Proficiency.

- 3.14.9.1. Describe your organization's process for notifying Members, their Authorized Representatives, and Providers of service authorization decisions, including Adverse Benefit Determinations, and explain how you ensure compliance with timeliness requirements under 42 CFR § 438.404(c)³⁹ and accessibility requirements for individuals with Limited English Proficiency and disabilities under 42 CFR § 438.10(a)⁴⁰.

3.14.10 Other Service Authorization Provisions

Special authorization rules, including EPSDT-consistent review for Members under 21 and exemptions for emergency services, protect statutory coverage standards and ensure timely access in urgent situations. Additional requirements for rapid outpatient drug authorization decisions support timely treatment and regulatory compliance.

- 3.14.10.1. Describe your organization's process for reviewing and authorizing service requests for Members under age twenty-one (21) in accordance with EPSDT criteria, ensuring that emergency services are not subject to prior authorization, and issuing decisions for covered outpatient drug authorizations within twenty-four (24) hours by telephone or other telecommunication device in compliance with 42 CFR § 438.3⁴¹, Section 1927(d)(5)(A) of the Social Security Act⁴², and NCQA standards.

3.14.11 Adverse Benefit Determination and Appeal

Standardized adverse benefit determination notices and appeal rights provide Members with procedural protections when authorization decisions impact coverage. These requirements promote transparency, ensure compliant communications, and preserve Members' ability to challenge Medical Necessity determinations.

- 3.14.11.1. Describe your process for providing written Notices of Adverse Benefit Determination or Coverage Decision Letters to Members, their Authorized Representatives, and Providers, including how you ensure that content and

³⁹ 42 CFR § 438.404(c) - <https://www.ecfr.gov/current/title-42/section-438.404>

⁴⁰ 42 CFR § 438.10(a) - <https://www.ecfr.gov/current/title-42/section-438.10>

⁴¹ 42 CFR § 438.3 - <https://www.ecfr.gov/current/title-42/section-438.3>

⁴² Social Security Act Section 1927(d)(5)(A) - https://www.ssa.gov/OP_Home/ssact/title19/1927.htm

timing comply with 42 CFR § 438.404⁴³ and how Members are informed of their right to appeal Medical Necessity decisions.

3.14.12 Expedited Service Authorization

Expedited authorization processes protect Members when delays could jeopardize health or functional status. Defined timelines and extension rules ensure urgent decisions are made quickly while preserving documentation and Member protections.

No response is required for this section.

3.14.13 Post Authorization

Retrospective review standards support timely resolution of post-service authorization decisions while protecting providers and Members from inappropriate retractions. Limitations on rescinding approvals reinforce reliance protections and promote administrative fairness.

No response is required for this section.

3.14.14 Service Authorization Approvals

Prompt provider notification of approvals supports timely scheduling and delivery of non-emergency care. Standard verbal and written notification requirements reduce delays and promote clear communication between the Contractor and providers.

- 3.14.14.1. Describe your process for notifying Providers of non-emergency service authorization approvals, including how you ensure verbal notice within one (1) business day and written notice within two (2) business days of the initial determination, or sooner if required by the Member's health condition

3.14.15 Adverse Action

Clear notice standards for denials and partial approvals ensure Members and providers understand decisions, next steps, and applicable rights. Consistent notice content and timelines support due process and alignment with federal requirements for accessible communications.

- 3.14.15.1. Describe your process for providing written notices to Members when a service authorization request is denied, partially approved, or otherwise limited, ensuring that the notice is written in plain language that is easily understood by the Member.
- 3.14.15.2. Explain how your organization ensures that all notices of action are consistent with the requirements of 42 CFR §§ 438.404, 438.10⁴⁴, and 438.210⁴⁵, as well as with EOHHS requirements for Member communications and any applicable agreements related to the content of denial or partial denial notices.

3.14.16 Informal Reconsideration

An informal reconsideration pathway supports timely clinical dialogue and early resolution of adverse determinations without delaying formal appeal timeframes. Rapid peer-to-peer review processes can improve accuracy, reduce administrative burden, and support appropriate care

⁴³ 42 CFR § 438.404 - <https://www.ecfr.gov/current/title-42/section-438.404>

⁴⁴ 42 CFR § 438.10 - <https://www.ecfr.gov/current/title-42/section-438.10>

⁴⁵ 42 CFR § 438.210 - <https://www.ecfr.gov/current/title-42/section-438.210>

decisions.

- 3.14.16.1. Describe your organization's Informal Reconsideration process for adverse determinations, including how Members (or Providers/agents on their behalf with written consent) are given the opportunity to present evidence and allegations of fact or law in person or in writing, and how the process complies with 42 CFR § 438.402(c)(1)(ii)⁴⁶.
- 3.14.16.2. Explain how your organization ensures that informal reconsiderations occur within one (1) business day of the request, are conducted with the Provider rendering the service and an authorized physician or designated clinical peer, and do not extend the thirty (30) calendar day timeframe for a Notice of Appeal Resolution.

3.14.17 Service Authorization Requirements for New Enrollees

Continuity protections for new Members reduce disruptions in ongoing treatment by limiting prior authorization barriers during the initial transition period. These requirements support uninterrupted medically necessary services while allowing appropriate UM controls after defined timeframes.

- 3.14.17.1. Describe your organization's process for ensuring continuity of care for new Members, including how you authorize the continuation of Medically Necessary Covered Services during the first thirty (30) calendar days of enrollment without requiring prior authorization or denying services solely because they are delivered by an out-of-network Provider, and how you transition to prior authorization requirements after the initial thirty (30) days.

3.14.18 Special Health Care Needs

Enhanced continuity-of-care protections for Members with Special Health Care Needs help prevent disruption of active treatment during transitions into managed care. Extended continuation periods and restrictions on out-of-network denials support stability while Members are transferred safely to network providers.

- 3.14.18.1. Describe your organization's process for ensuring continuity and coordination of Medically Necessary Covered Services for new Enrollees with Special Health Care Needs (SHCN) during the first ninety (90) calendar days of enrollment, including how you prevent disruption of care, apply prior authorization requirements only after thirty (30) days, and ensure services are not denied solely because they are provided by a non-contract Provider.

3.14.19 Other Service Authorization Requirements

Additional authorization provisions support coordination across plans, protect access to emergency and EPSDT screening services, and ensure higher-level services are not discontinued without an appropriate alternative. Alignment across MCO policies reduces provider confusion and supports consistent statewide administration.

- 3.14.19.1. Describe your organization's process for authorizing and coordinating services,

⁴⁶ 42 CFR § 438.402(c)(1)(ii) - <https://www.ecfr.gov/current/title-42/section-438.402>

including how you comply with case-by-case directives from the Medicaid Director, avoid conflicting policies with other MCOs, ensure higher-level services are not denied unless appropriate care is available at a lower level, and confirm that no service authorization is required for emergency services, post-stabilization services, or EPSDT screenings.

3.14.20 Dental Health Record Review

Systematic dental record review strengthens program integrity and quality oversight by validating billed services, assessing documentation compliance, and identifying corrective action needs. Regular site reviews and structured reporting support accountability and ensure findings are integrated into broader quality, credentialing, and peer review activities.

- 3.14.20.1. Describe your organization's process for verifying that services reimbursed were actually provided to Members as billed, including how sampling or other verification methods are applied on a regular basis.
- 3.14.20.2. Explain your written strategy for conducting dental health record reviews, including how results are reported, corrective actions are identified and documented, and how updates to the strategy are submitted to EOHHS for approval.
- 3.14.20.3. Explain how your organization conducts routine Quality Assurance site visits, including how standards are communicated to Providers, how sites are selected and reviewed within a two-year cycle, how record samples are determined by Provider type or group size, and how results are reported quarterly and annually to EOHHS.

3.15. Program Integrity

3.15.1 General Requirements

Program integrity oversight establishes clear expectations for detecting, reporting, and responding to fraud, waste, and abuse across all Contractor operations. State-led direction required reporting protocols, and restrictions on excluded or debarred entities help protect Medicaid funds and ensure compliance with federal and state requirements.

- 3.15.1.1. Describe in detail how your organization will comply with all federal and state fraud, waste, and abuse (FWA) requirements, including but not limited to 42 CFR Part 455⁴⁷, 42 CFR § 438.608⁴⁸, 42 CFR § 438.610⁴⁹, and Section 1902(a)(68) of the Social Security Act⁵⁰.
- 3.15.1.2. Describe how your organization will adhere to the most current EOHHS Office of Program Integrity (OPI) Fraud and Abuse Standard Operating Procedures for referrals and reporting; and describe processes to ensure cooperation with all written direction from OPI regarding investigations, overpayments, and other program integrity activities.

⁴⁷ 42 CFR Part 455 - <https://www.ecfr.gov/current/title-42/part-455>

⁴⁸ 42 CFR § 438.608 - <https://www.ecfr.gov/current/title-42/section-438.608>

⁴⁹ 42 CFR § 438.610 - <https://www.ecfr.gov/current/title-42/section-438.610>

⁵⁰ Social Security Act Section 1902(a)(68) - https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

3.15.2 Fraud Prevention Program

A formal Fraud Prevention Program provides a structured approach to identify high-risk areas, prevent improper payments, and respond quickly to suspected fraud, waste, or abuse. Dedicated leadership, regular risk assessments, provider screening, staff training, confidential reporting, and continuous improvement elements strengthen prevention and early detection.

- 3.15.2.1. Describe your organization's Fraud Prevention Program in compliance with federal requirements (42 CFR Part 455⁵¹ and 42 CFR § 438.608⁵²) and all EOHHS standards. In your response, describe the structure, scope, and key components of the Fraud Prevention Program, the role, authority, and responsibilities of the designated Fraud Prevention Officer, including how this position provides executive oversight, ensures program compliance, and reports directly to the Dental Director, Chief Compliance Officer, and Board of Directors.
- 3.15.2.2. Describe how your organization will ensure the Fraud Prevention Officer will participate in required EOHHS quarterly oversight meetings, including those involving the Medicaid Fraud Control Unit.

3.15.3 Compliance Program

A comprehensive compliance program creates organization-wide accountability for meeting contractual, federal, and state requirements. Required elements—such as a designated compliance officer, board oversight, training, auditing, disciplinary standards, prompt issue resolution, and overpayment reporting—support ongoing monitoring and strengthen operational integrity.

- 3.15.3.1. Describe how your organization—and any subcontractors delegated responsibility for coverage of services or payment of claims—will implement and maintain a comprehensive Compliance Program in accordance with 42 CFR § 438.608 and all applicable EOHHS policies and procedures.

3.15.4 Engagement with EOHHS' Office of Program Integrity

Coordinated engagement with EOHHS' Office of Program Integrity ensures suspected fraud, abuse, and payment discrepancies are addressed consistently and within required timelines. Regular meetings, onsite reviews, documentation access, and State-led investigative authority reinforce oversight and help align Contractor activities with EOHHS priorities.

- 3.15.4.1. Describe your organization's procedures for identifying, investigating, and reporting suspected fraud and/or abuse involving Members, Providers, or Subcontractors.
- 3.15.4.2. Describe how your organization will comply with onsite reviews and requests for documentation and records from EOHHS and the Office of Program Integrity.

3.15.5 Cooperation with Other Agencies

Effective program integrity efforts require coordination with state and federal enforcement

⁵¹ 42 CFR Part 455 - <https://www.ecfr.gov/current/title-42/part-455>

⁵² 42 CFR § 438.608 - <https://www.ecfr.gov/current/title-42/section-438.608>

partners. Cooperation with entities such as the Medicaid Fraud Control Unit supports timely investigations and strengthens accountability across the Medicaid system.

No response is required for this section.

3.15.6 Program Integrity Staff

Adequate staffing—including a compliance officer and dedicated SIU or audit personnel—supports timely investigations, case tracking, and responsive coordination with the State. In-state investigative capacity and clear points of contact help ensure rapid escalation and resolution of program integrity issues.

- 3.15.6.1. Describe your organization’s staffing plan for compliance and fraud prevention, including the Special Investigations Unit (SIU) and/or auditing unit, in accordance with Article 3 - Section 14.5 requirements.

3.15.7 Provider Site Audits

Routine provider site audits and statistically valid record sampling are core tools for identifying billing anomalies and verifying services were delivered as claimed. Defined audit volumes, repayment/offset mechanisms, corrective payments for underpayments, and EOHHS audit authority support consistent fiscal stewardship.

- 3.15.7.1. Describe your organization’s procedures for conducting Provider Site Audits and statistically valid sampling to ensure program integrity and compliance with EOHHS requirements.

3.15.8 Fraud, Waste and Abuse Compliance Plan

A written, EOHHS-approved FWA compliance plan establishes the Contractor’s specific policies, controls, and accountability structure for program integrity operations. Required submission timelines, annual updates, and approval processes ensure the plan remains current and responsive to emerging risks.

- 3.15.8.1. Describe how your organization will develop, maintain, and implement a written FWA Compliance Plan that includes all related policies and procedures, including timeline, approvals, annual reviews and updates.

3.15.9 Fraud, Waste and Abuse Compliance Plan Requirements

Detailed plan requirements ensure the Contractor documents its prevention and detection controls, investigation workflows, exclusion monitoring, confidentiality and non-retaliation protections, and provider oversight procedures. Specific expectations for automated edits, audits, site visits, reporting channels, and monthly exclusion checks strengthen consistency and transparency.

- 3.15.9.1. Describe or provide a copy of your organization's FWA Compliance Plan including all EOHHS requirements.

3.15.10 Investigation and Reporting of Fraud, Waste and Abuse

Timely investigation and immediate reporting to EOHHS ensures suspected fraud or abuse is handled under State-led protocols and preserves investigative integrity. Restrictions on provider contact and settlements without approval help prevent interference with State investigations while allowing appropriate network actions when warranted.

- 3.15.10.1. Describe your organization’s procedures for detecting, investigating, and

reporting suspected fraud, waste, and abuse (FWA) related to all services provided under this Agreement, including subcontracted functions.

- 3.15.10.2. Describe your organization's protocols following the identification or reporting of substantiated or suspected fraud or abuse, including actions to ensure compliance with EOHHS restrictions.

3.15.11 Overpayments

Overpayment review processes require State oversight to prevent inappropriate claim holds and ensure review activity is time-limited and justified. Pre-approval requirements, defined review durations, and controlled look-back periods help balance recovery efforts with fair provider payment practices.

- 3.15.11.1. Describe your organization's policies and procedures for conducting pre- and post-payment reviews related to potential overpayments in compliance with EOHHS and the Office of Program Integrity (OPI) requirements

3.15.12 Recoupment

Recoupment rules define when and how Contractor recoveries may occur and prevent duplicate or conflicting recovery actions across state investigations, RAC activities, or litigation. Reporting obligations and coordination requirements ensure recoveries are permissible, transparent, and appropriately returned when prohibited.

- 3.15.12.1. Describe your organization's procedures for recovering and reporting overpayments identified through audits or investigations in compliance with EOHHS and the Office of Program Integrity (OPI) requirements.
- 3.15.12.2. Describe your organization's internal controls and procedures to ensure no recoupment or withhold actions are taken against Providers in violation of EOHHS policies or federal/state restrictions.

3.15.13 Suspension of Payment

Payment suspension requirements ensure immediate action when EOHHS imposes or lifts suspensions tied to credible allegations of fraud. Tight timeframes, subcontractor pass-through requirements, and reporting expectations help prevent continued payment during investigations and reduce improper disbursements.

- 3.15.13.1. Describe how your organization will conduct its due diligence and investigations to determine when a case meets the definition of a credible allegation of fraud; and the process for immediately reporting such cases to the EOHHS Office of Program Integrity (OPI).

3.15.14 Credible Allegation of Fraud

Credible allegation standards establish a defined escalation pathway from Contractor investigation to State determination and possible referral to MFCU. Monthly reporting and enforcement remedies reinforce accountability when required payment suspensions or reporting obligations are not completed accurately.

No response is required for this section.

3.15.15 Provider Terminations

Provider termination and exclusion requirements protect the program from paying entities that are sanctioned, debarred, or otherwise ineligible to participate. Regular review of sanctioned provider lists and required termination actions help maintain network integrity and prevent reimbursement for excluded providers except as permitted for emergencies.

- 3.15.15.1. Describe your organization's policies and procedures for identifying and ensuring that excluded, debarred, or sanctioned Providers do not participate in the RItE Smiles 4-ALL Program, in compliance with federal and EOHHS requirements.

3.16. Operational Data Reporting

3.16.1 General

This section establishes the State's overarching reporting framework, including required formats, schedules, submission standards, and the expectation that the Contractor produces complete, accurate electronic reports that remain adaptable to evolving EOHHS requirements.

- 3.16.1.1. Describe your organization's capacity and processes for ensuring full compliance with all EOHHS reporting requirements under this Contract.

3.16.2 Encounter Data Reporting

Encounter data reporting ensures EOHHS receives complete, accurate, and timely service records for all covered services where the Contractor (or subcontractors) has financial liability, supporting program oversight, payment integrity, and standardized statewide data use.

- 3.16.2.1. Describe your organization's policies and procedures to ensure the complete, accurate, and timely submission of encounter data in compliance with 42 CFR § 438.242(c)⁵³ and all applicable EOHHS guidance documents.

3.16.3 Timeliness and Accuracy of Data Submittal and Correction of Rejected Claims

This section reinforces expectations for high-quality encounter submissions by requiring timely monthly reporting, minimal rejection rates, compliance with system edits, and prompt correction and resubmission of rejected transactions to prevent persistent data gaps.

Include this information in response to 3.16.2.1

3.16.4 Data Validation

Data validation requirements support transparency and accountability by requiring reconciliation and attestation of encounter submissions, routine file status reporting, documentation of variances, and alignment between encounter reporting and financial cost reporting within defined thresholds.

- 3.16.4.1. Describe your organization's processes for reconciling and validating encounter data, including subcontractor data, to ensure completeness and accuracy in accordance with EOHHS requirements.
- 3.16.4.2. Describe how your organization will ensure accurate reporting, monitoring, and reconciliation of encounter data and financial submissions.

3.16.5 Participation in Encounter Data Meetings

⁵³ 42 CFR § 438.242(c) - <https://www.ecfr.gov/current/title-42/section-438.242>

Regular encounter data meetings create a structured forum for the State and Contractor to review submission performance, explain variances, address processing issues, and ensure encounter totals align with incurred liabilities reflected in the State's systems.

- 3.16.5.1. Describe how your organization will participate in regular encounter data meetings with the State and submit required 837 processing reports at the frequency and schedule defined by EOHHS.

3.16.6 Penalties for Non-Compliance

This section outlines the State's enforcement tools—financial penalties and operational sanctions—to address persistent encounter data quality issues, ensuring Contractors maintain acceptable denial rates and meet reporting standards necessary for effective program administration.

- 3.16.6.1. Describe your organization's plan to monitor, prevent, and mitigate non-compliance related to encounter data submissions to ensure adherence to EOHHS performance standards and avoid sanctions and maintain an encounter data denial rate below two percent (2%).

3.16.7 Grievance and Appeals Data Report

Quarterly grievance and appeals reporting enables the State to monitor volume, trends, and timeliness of dispute resolution activities, supporting oversight of member protections and system responsiveness.

No response is required for this section.

3.16.8 Quality Assessment and Performance Improvement Report

These requirements ensure EOHHS has visibility into the Contractor's internal quality monitoring and improvement activities, including record abstracts and timely sharing of study findings and standardized performance results.

- 3.16.8.1. Describe your organization's approach to quality assessment and performance improvement (QAPI) reporting in compliance with EOHHS requirements.

3.16.9 Member and Provider Satisfaction Report

Annual satisfaction reporting provides structured feedback from Members and Providers across population groups, helping identify service barriers, experience trends, and priorities for program improvement.

- 3.16.9.1. Describe your process for collecting satisfaction data from Providers and Members, including a representative sample of each sub-group and specialty.

3.16.10 Fraud and Abuse Report

Quarterly fraud and abuse reporting ensures the State receives consistent information about suspected fraud and investigative activity, including case details needed to support program integrity oversight and referral tracking.

- 3.16.10.1. Describe your organization's quarterly fraud and abuse report that demonstrates your understanding of the State's specifications.

3.16.11 Recovery Reporting

Recovery reporting establishes a standardized mechanism for identifying, returning, and explaining overpayments within required timeframes, while ensuring EOHHS receives annual totals and timely notice of capitation overpayments.

- 3.16.11.1. Describe your organization's policies and procedures for identifying, reporting, and returning overpayments in compliance with 42 CFR Part 433 Subpart F⁵⁴ and EOHHS requirements.

3.16.12 Presentation of Findings

This provision protects the integrity and confidentiality of program-related analytics by requiring State approval before the Contractor publicly releases or presents statistical or analytical findings based on member enrollment data.

No response is required for this section.

3.16.13 HIPAA Requirements

HIPAA requirements confirm the Contractor will meet applicable privacy, transaction, and operational standards, including required coverage documentation and reporting to EOHHS or its designee.

- 3.16.13.1. Attestation: The Contractor affirms full compliance with the Health Insurance Portability and Accountability Act (HIPAA) operational, privacy, security, and information system requirements.

3.16.14 Certification of Data

Data certification ensures accountability by requiring the Contractor to formally attest that submitted information is accurate, complete, and truthful, using EOHHS-approved forms and processes.

Include this information in response to 3.16.13.1

3.16.15 Patient Protection and Affordable Care Act (ACA)

This section establishes expectations that the Contractor complies with applicable ACA operating rules and reporting standards, supporting consistent administrative and data practices across the program.

Include this information in response to 3.16.13.1

3.17. Grievances and Appeals

3.17.1 General Requirements

Members must be able to file grievances at any time, including through providers or authorized representatives. An internal grievance and appeals process is required that aligns with federal law and NCQA standards, and includes grievances, a single-level appeal process, and access to the State Fair Hearing process.

- 3.17.1.1. Describe your organization's internal Grievance and Appeals Procedure in compliance with 42 CFR Part 438 Subpart F⁵⁵, the Social Security Act (42 USC

⁵⁴ 42 CFR Part 433, Subpart F - <https://www.ecfr.gov/current/title-42/part-433/subpart-F>

⁵⁵ 42 CFR Part 438 Subpart F - <https://www.ecfr.gov/current/title-42/part-438/subpart-F>

§ 1396a⁵⁶), and NCQA accreditation standards.

3.17.2 Grievances and Appeals Policies and Procedures

Clear, accessible policies must outline fair hearing rights, filing timeframes, and available supports such as interpreter services and TTY access. Decision-makers must be impartial and clinically appropriate when needed, and the Contractor must cooperate with dual eligible integrated processes and allow State oversight, audits, and inspections.

- 3.17.2.1. Describe your organization's procedures for ensuring that decision makers in the Grievance and Appeals processes meet all EOHHS requirements for independence, qualifications, and oversight, including the appropriate clinical dental experience.

3.17.3 Grievances

Grievances may be submitted orally or in writing and must be acknowledged promptly. Resolutions must be issued within required timeframes, with limited extensions allowed only when justified and accompanied by appropriate Member notification and rights information.

- 3.17.3.1. Describe your organization's Grievance process for Members, Providers, and Authorized Representatives in compliance with 42 CFR § 438.10⁵⁷ and EOHHS requirements.
- 3.17.3.2. Describe your organization's procedures for resolving Grievances and managing extensions of resolution timeframes in accordance with EOHHS standards.

3.17.4 Appeals

Appeals must be accepted within required timelines following an adverse benefit determination, with written acknowledgement and defined resolution deadlines. Oral appeals generally require written follow-up unless expedited, and Members must have a clear path to a State Fair Hearing if timelines are not met.

- 3.17.4.1. Describe your organization's procedures for acknowledging and resolving Appeals within the required timeframes.

3.17.5 Resolving a Standard Appeal

Members must have meaningful opportunities to present evidence and arguments, including access to their case file at no cost. Written appeal decisions must clearly explain outcomes, next steps, and options for further review or continuation of benefits.

- 3.17.5.1. Describe how your organization ensures that Members, Authorized Representatives, or legal representatives of deceased Members' estates may fully participate in the Appeal process and have a reasonable opportunity to present evidence, testimony, and arguments both in person and in writing.
- 3.17.5.2. Describe your organization's procedures for issuing written and oral notices of Appeal determinations in compliance with 42 CFR § 438.10.

⁵⁶ 42 USC § 1396a - [https://uscode.house.gov/view.xhtml?req=\(title:42%20section:1396a%20edition:prelim\)](https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396a%20edition:prelim))

⁵⁷ 42 CFR § 438.10 - <https://www.ecfr.gov/current/title-42/section-438.10>

3.17.6 Timeliness for Resolving an Expedited Appeal

Expedited appeal processing must be available when delay could seriously jeopardize health or functioning. Members must be able to submit expedited requests verbally, and decisions must be completed within required timeframes, with prompt notice provided when expedited handling is denied.

- 3.17.6.1. Describe your organization's procedures for handling, resolving, communicating and issuing notices regarding Expedited Appeals in compliance with EOHHS and 42 CFR § 438.410⁵⁸ requirements.

3.17.7 Extending a Standard or Expedited Appeal

Extensions may be granted when requested or when additional information is needed and the delay supports the Member's best interest. When extensions are not Member-requested, prompt oral and written notice must explain the reason and preserve the Member's right to dispute the delay.

Include this information in response to 3.17.6.1

3.17.8 Adverse Benefit Determination

Notices must explain the determination, the reasoning, and how to access relevant documents at no cost. Appeal rights, fair hearing rights, expedited options, and continuation of benefits provisions must be clearly described in language and formats that meet accessibility standards.

Include this information in response to 3.17.6.1

3.17.9 Timelines for a Notice of Adverse Benefit Determination

Advance notice requirements must be followed when services are reduced, suspended, or terminated, with shortened notice allowed only in limited circumstances such as verified fraud concerns. Limited extensions may be permitted when requested or justified and properly communicated.

Include this information in response to 3.17.6.1

3.17.10 Expedited Notice of Adverse Benefit Determination

When standard authorization timelines could cause serious harm, expedited determinations and notices must be issued quickly, generally within seventy-two (72) hours, with extensions allowed only when justified and in the Member's best interest.

Include this information in response to 3.17.6.1

3.17.11 Special Circumstances for Mailing Notice on the Date of Action

Same-day notice is permitted only in narrowly defined situations, such as confirmed death, institutionalization, unknown whereabouts, or written service refusal with documented understanding. Denials of payment may be noticed on the date of determination.

Include this information in response to 3.17.6.1

3.17.12 Continuation of Benefits

Continuation of benefits must be offered during an appeal when required conditions are met, including timely filing and request requirements. Coverage continues until the appeal is

⁵⁸ 42 CFR § 438.410 - <https://www.ecfr.gov/current/title-42/section-438.410>

withdrawn, deadlines for further escalation lapse, or an adverse fair hearing decision is issued.

- 3.17.12.1. Describe how your organization will ensure benefits continue when a Member files an Appeal within sixty (60) calendar days of the Notice of Adverse Benefit Determination.

3.17.13 Payment for Continued Services

Responsibility for payment depends on the final outcome—continued services must be covered when determinations are reversed, and recovery of costs may be allowed when decisions are upheld, consistent with Rhode Island policy.

- 3.17.13.1. Describe your organization's procedures for preparing and submitting quarterly Grievances and Appeals reports in accordance with the Managed Care Manual and EOHHS requirements.
- 3.17.13.2. Describe your organization's approach to maintaining Grievance and Appeal records and meeting EOHHS performance standards. including how your organization maintains complete and accurate records for each Grievance or Appeal, Member details, reason(s), review dates, and resolution outcomes.

3.17.14 Restoring Benefits

Benefits must be reinstated promptly following a reversal, including rapid service authorization to prevent gaps in medically necessary care.

No response is required for this section.

3.17.15 External Dental Review

Members must have access to an external appeal process through an independent reviewer under Rhode Island external review requirements for benefit determinations.

No response is required for this section.

3.17.16 Complaint Resolution

Internal resolution is strongly encouraged, supported by written procedures and a documented tracking system for Member and Provider complaints. Complaint reports must be produced when requested by the State.

No response is required for this section.

3.17.17 Grievances and Appeals Reporting

Quarterly reporting must include aggregate grievance and appeal activity, trend analysis, identification of systemic issues, and corrective action plans where needed. Performance standards apply, and detailed recordkeeping is required for each grievance and appeal.

- 3.17.17.1. Describe your organization's procedures for preparing and submitting quarterly Grievances and Appeals reports in accordance with the Managed Care Manual and EOHHS requirements including and not limited to how your organization compiles aggregate analyses of Grievances and Appeals activity; identifies systemic issues; tracks trends; and how corrective action plans are developed and implemented in response to identified issues.

3.17.18 Grievance and Appeals Records Retention

Grievance and appeal records must be maintained for ten years and made available for State and federal review. All grievances must be logged, tracked, and trended, regardless of severity or whether the Member explicitly requests formal processing.

- 3.17.18.1. Describe how your organization shall collect, log, track, trend and maintain a complete and accurate record of all Grievances and Appeals for ten (10) years.

3.18. Payments To and From Plans

3.18.1 General Capitation Payments

Capitation payments may only be made by the State for eligible managed care Members receiving Covered Services, and rates must meet federal requirements and CMS approval standards. The Contractor must attest to the accuracy of claims and payment data, cover required supplemental services when applicable and may not shift costs by referring Members to publicly funded resources.

- 3.18.1.1. Describe your organization's compliance procedures for ensuring the accuracy, completeness, and truthfulness of claims and payment data submitted to EOHHS, in accordance with 42 CFR §§ 438.3(c)⁵⁹, 457.1201(o)⁶⁰, 457.1240(b)⁶¹, and 457.1250(a)⁶².

3.18.2 Acceptance of State Capitation Payments

The Contractor must accept capitation payments as full reimbursement for in-plan services under the terms of the Agreement and established rate schedule. Payments are made monthly based on State enrollment rosters, with limited circumstances for rate changes and a requirement for written processes to receive, track, and process capitation and enrollment information.

3.18.2.1. Contractor Attestation Statement

Pursuant to the requirements of 42 CFR §§ 438.3(c), 457.1201(o), 457.1240(b), 457.1250(a), and related provisions, the Bidder must attest and certify to the following:

- **Capitation and Payment Compliance**
The Contractor acknowledges that EOHHS shall make final capitation rate and payment determinations and agrees to comply with all applicable federal and state regulations governing payment methodology and rate-setting.
- **Data Accuracy Certification**
The Contractor attests, under penalty of perjury, that all claims, encounter, and payment data submitted to EOHHS are accurate, complete, and truthful to the best of the Contractor's knowledge, information, and belief.
- **Cost Avoidance Guarantee**
The Contractor guarantees that it will not avoid costs for covered services under this Contract by referring Members to publicly supported health care resources and will

⁵⁹ 42 CFR § 438.3(c) - <https://www.ecfr.gov/current/title-42/section-438.3>

⁶⁰ 42 CFR § 457.1201(o) - [https://www.ecfr.gov/current/title-42/part-457/section-457.1201#p-457.1201\(o\)](https://www.ecfr.gov/current/title-42/part-457/section-457.1201#p-457.1201(o))

⁶¹ 42 CFR § 457.1240(b) - [https://www.ecfr.gov/current/title-42/part-457/section-457.1240#p-457.1240\(b\)](https://www.ecfr.gov/current/title-42/part-457/section-457.1240#p-457.1240(b))

⁶² 42 CFR § 457.1250(a) - <https://www.ecfr.gov/current/title-42/section-457.1250>

maintain appropriate utilization management to ensure services are provided in accordance with contractual obligations.

3.18.3 Payments to Providers

Provider reimbursement must support timely payment practices while allowing flexibility for value-based or alternative arrangements that improve quality and efficiency. The Contractor must pay in-network and authorized out-of-network claims within required timelines, comply with special payment rules for FQHCs, RHCs, and hospital-based clinics, and ensure Members are protected from balance billing.

- 3.18.3.1. Describe how your organization will make timely payments to both its contracted and non-contracted Providers; and abide by the special reimbursement provisions for RI's FQHCs and RHCs.
- 3.18.3.2. Describe how your policy and protocols for unique payments to FQHC, hospitals, ASCs, in-network and out-of-network Providers.
- 3.18.3.3. Explain how your organization will make timely payments and meet the requirements of 42 CFR § 447.45⁶³ and 42 CFR § 447.46⁶⁴ for out-of-network Providers for medically necessary, covered services when services were prior authorized.

3.18.4 Dental Provider Incentive Plans

Provider incentive arrangements must comply with federal requirements and cannot place dentists at substantial financial risk in ways that discourage appropriate care or referrals. Incentive structures must support access and quality while meeting defined operational and reporting standards.

No response is required for this section.

3.18.5 Cost Sharing

Rhode Island currently does not require cost sharing for RIte Smiles 4-ALL Members but retains the right to implement it in the future consistent with federal Medicaid rules. If cost sharing is introduced, the Contractor must implement compliant policies and ensure Member responsibilities are appropriately managed.

No response is required for this section.

3.18.6 Alternative Payment Methodology (APM)

The program promotes movement away from fee-for-service toward value-based payment approaches that improve outcomes, experience, access, and cost efficiency. The Contractor must progressively integrate alternative payment methodologies into provider contracts to align incentives with quality and population health goals.

- 3.18.6.1. Detail any APM model(s) you might propose to implement as part of a value-based incentive program.

3.18.7 Exemption for Native Americans Served by Indian Healthcare

⁶³ 42 CFR § 447.45 - <https://www.ecfr.gov/current/title-42/section-447.45>

⁶⁴ 42 CFR § 447.46 - <https://www.ecfr.gov/current/title-42/section-447.46>

Native American Members receiving services through I/T/U providers or Indian Health programs must not be charged enrollment fees or other cost-sharing amounts for Medicaid-covered services. The Contractor must reimburse these providers at the full Medicaid rate without reducing payments based on charges that would otherwise apply.

No response is required for this section.

3.18.8 Health Insurer Fee

If the Contractor is subject to the federal Health Insurer Fee, the State may provide a retrospective annual payment and actuarially sound capitation adjustment, subject to State funding and CMS approval. Payment amounts must be supported by federal tax filings and official IRS documentation.

No response is required for this section.

3.18.9 Third-Party Liability

Medicaid remains the payer of last resort, requiring the Contractor to identify and pursue third-party resources before Medicaid pays when appropriate. The Contractor must manage TPL identification, reporting, recovery timelines, and policy submission requirements, while coordinating data matching efforts and providing timely responses to State requests.

- 3.18.9.1. Describe your organization's Third-Party Liability (TPL) program and procedures to ensure compliance with Section 1902(a)(25) of the Social Security Act⁶⁵ and 42 CFR § 433.139⁶⁶.

Your response must include:

- How your organization identifies, verifies, and reports legally liable third parties responsible for Members' healthcare costs;
- How it maintains and submits TPL coverage and collection data to EOHHS on a weekly basis in the format required; and
- How it designates and utilizes a TPL contact person responsible for coordination, compliance, and reporting.

3.18.10 Reinsurance

The Contractor must obtain reinsurance coverage from a source other than the State as a condition of contract award. The State may review coverage adequacy and require adjustments if needed to protect program stability and financial performance.

No response is required for this section.

3.18.11 Reserving

The Contractor must maintain actuarially sound methods for tracking and estimating incurred but not reported claims (IBNR) and regularly review the accuracy of reserves. Annual look-back analyses are required to validate reserving assumptions and adjust methodology when needed.

- 3.18.11.1. Describe your organization's actuarially sound process for estimating and

⁶⁵ Social Security Act Section 1902(a)(25) - https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

⁶⁶ 42 CFR § 433.139 - <https://www.ecfr.gov/current/title-42/section-433.139>

tracking incurred but not reported (IBNR) claims, including annual look back analysis.

3.18.12 Claims Processing and MIS

Claims and management information systems must be capable of supporting timely provider payments and required reporting functions. The Contractor must also be able to expand system capacity if enrollment growth increases processing or reporting demands.

- 3.18.12.1. Describe in detail your organization's claims processing system and Management Information System (MIS), its infrastructure and the organization's capacity to efficiently and effectively support the Provider payment and data reporting requirements specified in the Model Contract. Include any new technology such as AI, and its capability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of Members.

3.18.13 Audits

The State retains the right to conduct audits to verify capitation payments, invoicing accuracy, and third-party liability processes. Findings may result in repayment demands, offsets, referrals for investigation, or corrective payments, with disputes addressed through contract-established resolution procedures.

- 3.18.13.1. Describe your organization's procedures for cooperating with State and EOHHS audit activities to ensure transparency and compliance with contractual and regulatory requirements, including how your organization facilitates State or designee audits verifying proper invoicing, payments, and Third-Party Liability (TPL) identification; and maintains documentation and internal controls to support audit readiness and accuracy of all financial transactions related to this Agreement.
- 3.18.13.2. Describe your organization's process for responding to audit findings and reconciling payment discrepancies identified by the State or its designees.

3.19. Financial Standards

3.19.1 General

Rhode Island requires all licensed Health and Dental Plans to meet financial stability standards overseen by the Department of Business Regulation. The Contractor must comply with DBR requirements in addition to the specific financial standards and obligations outlined in the Agreement.

No response is required for this section.

3.19.2 Financial Benchmarks

Participation in Rhode Island Medicaid managed care depends on the Contractor maintaining ongoing financial solvency and operational capacity under a risk-based contract. The Contractor must regularly demonstrate financial viability to EOHHS and meet solvency requirements established through the Office of the Health Insurance Commissioner, including providing annual benchmark data and completing any corrective actions required by the State.

- 3.19.2.1. Describe your organization's approach to ensuring financial stability and solvency in compliance with EOHHS and Rhode Island Office of the Health Insurance Commissioner (OHIC) requirements. Include how your organization demonstrates ongoing financial solvency, capital adequacy, and management capability to operate under a risk-based contract; and how it will provide annual financial documentation and benchmark data to EOHHS to evaluate fiscal performance for the RIte Smiles 4-ALL line of business.

3.19.3 Financial Data Reporting

The Contractor must submit complete and timely financial reports required under Rhode Island Medicaid managed care financial reporting standards, including NAIC filings, audited statements, insurance coverage documentation, cost reports, MLR templates, and other reports tied to material financial changes. These submissions support State oversight of financial condition and contract performance.

- 3.19.3.1. Describe in detail your organization's policy that will ensure compliance with the Rhode Island Medicaid Managed Care Health Plan Financial Reporting.

3.19.4 Medical Loss Ratio (MLR) Reporting

The Contractor must calculate and report Medicaid Medical Loss Ratio results annually using the State's required workbook and provide all supporting data needed to confirm actuarially sound capitation rates and compliance with federal MLR standards. The Contractor must also ensure vendors supporting claims adjudication provide necessary MLR source data within required timeframes to allow accurate validation and State reporting.

- 3.19.4.1. Describe your organization's process for preparing and submitting the consolidated Medical Loss Ratio (MLR) report using the EOHHS-provided MLR Calculation Workbook and template.

3.19.5 Audit

The Contractor must provide independent audited financial statements within required deadlines when contract expenditure thresholds are met, including audits specific to this contract line of business. Audits must follow generally accepted accounting principles and auditing standards and include full disclosure of the Contractor's financial position and performance.

- 3.19.5.1. Describe how your organization will ensure that all audits are conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards (GAAS), including how your organization will ensure that each audit is specific to this contract; and that your audit process aligns with federal requirements under 42 CFR § 438.3(m)⁶⁷ and provides transparency into the Contractor's financial operations and compliance.

3.20. Record Retention

3.20.1 General

⁶⁷ 42 CFR § 438.3(m) - <https://www.ecfr.gov/current/title-42/section-438.3>

The Contractor must maintain, and ensure subcontractors maintain, required program records—including grievance and appeal records, base data, MLR documentation, and other federal compliance and program integrity records—for a minimum of ten (10) years in accordance with applicable federal requirements.

- 3.20.1.1. Describe your organization’s policies and procedures for record retention and data management in compliance with 42 CFR §§ 438.5(c)⁶⁸, 438.8(k)⁶⁹, 438.604⁷⁰, 438.606⁷¹, 438.608⁷², 438.610⁷³, and 438.416⁷⁴, as well as EOHHS requirements.

3.20.2 Operational Data Reports

The Contractor must retain source documentation supporting all operational and financial data reports for at least ten (10) years and maintain written policies and procedures that describe how records are stored, safeguarded, and made available as needed.

No response is required for this section.

3.20.3 Dental Records

The Contractor must preserve Member dental/medical records for at least ten (10) years following the expiration of the Agreement, and longer when records are associated with litigation, in which case they must be retained throughout the legal proceeding and for seven (7) years after final resolution.

No response is required for this section.

3.21. Compliance

3.21.1 General Requirements

The Contractor must maintain an active compliance program—supported by a written Compliance Plan and appropriate administrative safeguards—to prevent, detect, and respond to fraud, waste, and abuse. The Compliance Plan, including supporting policies, procedures, workflows, and organizational structure, must be submitted electronically to EOHHS for review and approval within required timeframes and updated annually.

- 3.21.1.1. Describe your organization’s process for developing, maintaining, and submitting a mandatory written Compliance Plan to EOHHS in accordance with 42 CFR § 438.608. Your response must include how your organization ensures timely submission of the plan, including all policies, procedures, workflows, and organizational charts, within ninety (90) days of contract execution and annually thereafter.
- 3.21.1.2. Describe the governance structure supporting your compliance program. Your response must include details on the designation of a Compliance Officer, the

⁶⁸ 42 CFR § 438.5(c) - <https://www.ecfr.gov/current/title-42/section-438.5>

⁶⁹ 42 CFR § 438.8(k) - <https://www.ecfr.gov/current/title-42/section-438.8>

⁷⁰ 42 CFR § 438.604 - <https://www.ecfr.gov/current/title-42/section-438.604>

⁷¹ 42 CFR § 438.606 - <https://www.ecfr.gov/current/title-42/section-438.606>

⁷² 42 CFR § 438.608 - <https://www.ecfr.gov/current/title-42/section-438.608>

⁷³ 42 CFR § 438.610 - <https://www.ecfr.gov/current/title-42/section-438.610>

⁷⁴ 42 CFR § 438.416 - <https://www.ecfr.gov/current/title-42/section-438.416>

establishment of a Regulatory Compliance Committee at both Board and senior management levels, and how these roles provide oversight, accountability, and compliance assurance across all delegated entities.

- 3.21.1.3. Describe how your organization's compliance program ensures ongoing monitoring, auditing, and prompt reporting of potential non-compliance, overpayments, or fraud. Your response must include how your organization: Maintains a compliance program with ongoing monitoring and auditing, the prompt referral of suspected fraud, waste, or abuse to EOHHS integrity units, notification to the State of provider eligibility or termination changes, suspension of payments for credible fraud allegations, and the assurance that all network providers are properly disclosed, screened, and enrolled in Medicaid in accordance with federal regulations.

3.21.2 SUPPORT Act Requirements

The Contractor must implement federally required automated opioid-related safety edits and prescribing alerts, including refill and dosage monitoring, to support appropriate medication oversight and reduce the risk of unsafe or excessive controlled substance use.

No response is required for this section.

3.21.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies

The Contractor must ensure it does not knowingly maintain prohibited relationships with individuals or entities that are excluded, debarred, or suspended from participation in federal procurement or federal health care programs, and must comply with required disclosure and reporting obligations if such affiliations are identified.

- 3.21.3.1. Describe how your organization ensures it does not knowingly have relationships with individuals or entities debarred, suspended, or excluded under Federal regulations (42 CFR § 438.610⁷⁵); and explain your procedures for identifying, disclosing, and addressing prohibited affiliations among directors, officers, partners, subcontractors, owners, and network Providers.

3.21.4 Disclosure of the Contractor's Ownership and Control Interest

The Contractor must provide complete and timely ownership and control disclosures in the format required by EOHHS, including updates after organizational changes, and must maintain documentation of all disclosure requests and responses for review by EOHHS or federal authorities upon request.

- 3.21.4.1. Describe your process for submitting full disclosure of ownership and control interests to EOHHS and the Secretary of HHS in accordance with 42 CFR § 455.104⁷⁶.

3.21.5 Disclosure by Providers: Information on Ownership and Control

The Contractor must require all contracted providers and disclosing entities to submit ownership

⁷⁵ 42 CFR § 438.610 - <https://www.ecfr.gov/current/title-42/section-438.610>

⁷⁶ 42 CFR § 455.104 - <https://www.ecfr.gov/current/title-42/section-455.104>

and control information consistent with Medicaid disclosure standards, ensure updates are provided when changes occur, and deny or terminate provider participation if required disclosures are not submitted.

- 3.21.5.1. Explain how you require network Providers and subcontractors to disclose ownership, control interests, significant business transactions, and criminal convictions under 42 CFR §§ 455.104–455.106⁷⁷.

3.21.6 Disclosure by Providers: Information Related to Business Transactions

The Contractor must require providers to supply full and complete information about significant business transactions and subcontractor ownership when requested, ensuring transparency in financial relationships that may impact Medicaid oversight and accountability.

- 3.21.6.1. Describe procedures for monitoring, verifying, and taking action (including denial or termination of agreements) when disclosures are incomplete or inaccurate.

3.21.7 Disclosures by Providers: Information on Persons Convicted of Crimes

Before entering into or renewing provider agreements, the Contractor must require disclosure of any owners, agents, or managing employees convicted of Medicaid- or Medicare-related offenses and must notify EOHHS when excluded individuals are identified and take appropriate actions to protect program integrity.

- 3.21.7.1. Explain your process for notifying EOHHS within ten (10) business days of any relevant disclosure or action affecting Provider participation, program integrity, or quality concerns.

3.21.8 Disclosures Made by Providers to the Contractor

The Contractor must track and report to EOHHS certain provider-related disclosures involving criminal convictions, civil penalties, or exclusions from federal health programs, and must promptly notify EOHHS of actions that limit or deny provider participation due to quality or program integrity concerns.

No response is required for this section.

3.21.9 Compliance with all Rhode Island Regulations

The Contractor must comply with all applicable Rhode Island laws and regulations affecting managed care operations, including requirements related to medication practices and external appeal processes.

- 3.21.9.1. Describe your procedures for ensuring compliance with all applicable Rhode Island regulations, including but not limited to medication synchronization, off-label prescription uses, and external appeals procedural requirements.

3.21.10 Compliance with Applicable Federal Regulation

The Contractor must comply with all relevant federal Medicaid managed care laws and regulations and work collaboratively with EOHHS to implement required changes within established federal

⁷⁷ 42 CFR §§ 455.104–455.106 - <https://www.ecfr.gov/current/title-42/section-455.104>, <https://www.ecfr.gov/current/title-42/section-455.105>, <https://www.ecfr.gov/current/title-42/section-455.106>

timeframes.

- 3.21.10.1. Describe how your organization ensures compliance with all applicable Federal laws and regulations, including implementation of the Medicaid and CHIP Managed Care Final Rule within specified time frames.

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Section E: Evaluation and Selection

1. Evaluation Process and Scoring

Proposals will be reviewed by a technical evaluation committee (“TEC”) comprised of staff from State agencies and non-scoring technical advisors if applicable and subject to approval by the Division of Purchases.

Section D-1, Bidder Mandatory Qualifications requires documentation demonstrating that the Bidder meets the mandatory qualifications to submit a bid. Section D-2, the Business Proposal has six (6) required elements. Sections D-1 and D-2 will each be evaluated on a Pass/Fail. Failure to satisfy any requirement in either section will result in the Bidder being excluded from further consideration under the solicitation.

Section D-3, the Technical Proposal is organized into twenty-one (21) sub-sections and includes 185 items, all of which bidders are required to answer. Each item will be scored against criteria that aligns with Article 3: Model Contract. Reviewers will use a structured scoring tool with a 1–4 rating scale against the criteria, where higher scores reflect a more complete and thorough response. Scores will be based on the Bidder’s demonstrated clarity, completeness, knowledge, experience, as well as gaps, omissions, flaws, defects, and overall alignment with solicitation requirements.

Technical proposals must receive a minimum of eighty-five (85) points out of a maximum of one hundred (100) points or eighty-five percent (85%) to advance to the Impact Small Business Enterprise (ISBE) evaluation phase.

Technical proposals scoring less than eighty-five points shall not have their accompanying ISBE participation proposals opened or evaluated; and such proposals shall not receive further consideration.

As total possible evaluation points are determined for bidders scoring eighty-five (85) points or more on the technical proposal, Bidder ISBE proposals shall next be evaluated and assigned up to six (6) points for ISBE participation.

Proposals shall be reviewed and scored based upon the criteria found on the following page.

Additional evaluation criteria can be found at the referenced locations below:

- For those with an OSP account, see the “Requirements” tab of this solicitation in OSP for additional information on the evaluation and selection process in the “RFP Standard Specification” section.
- For those without an OSP account, public access to the full bid can be found at <https://ridop.ri.gov/vendors/bidding-opportunities>. Search for this solicitation, open the record, click on the “Print/Download Solicitation Summary” button in the upper right corner for all the solicitation requirements and supporting documents are found at the bottom of the page in the “Solicitation Attachments” section.

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1.1. Proposal Point Matrix

Proposal		Possible Points
Section	Bidder Mandatory Qualifications	Pass/Fail
1.1	Federal MCO Definition	Pass/Fail
1.2	Experience and Enrollment Requirements	Pass/Fail
1.3	No Exclusion	Pass/Fail
1.4	Capacity to Perform	Pass/Fail
1.5	US Principal Place of Business	Pass/Fail
1.6	Accreditation Requirements	Pass/Fail
1.7	No Sanction Requirements	Pass/Fail
Section	Business Proposal	Pass/Fail
2.1	Cover Letter	Informational Only
2.2	Executive Summary of Proposal	Informational Only
2.3	Attestation to Agree to Meet Program Rules and Requirements	Pass/Fail
2.4	Licensure and Certification	Pass/Fail
2.5	Disclosure of Non-Compliance, Warning Letters, Litigation and Early Termination	Pass/Fail
2.6	Network Providers Letters of Intent	Pass/Fail
Section	Technical Proposal	Maximum Points
3.1	General	2.0
3.2	References	2.0
3.3	Dental Plan Administration	4.0
3.4	Eligibility and Program Enrollment	4.0
3.5	Dental Plan Enrollment and Disenrollment	3.0
3.6	In-Plan Services	4.0
3.7	Care Coordination	5.0
3.8	Provider Networks	8.0
3.9	Service Accessibility Standard	2.0
3.10	Marketing	3.0
3.11	Member Services	5.0
3.12	Provider Services	5.0
3.13	Quality Assessment and Performance Improvement	10.0
3.14	Utilization Management	10.0

3.15	Program Integrity	10.0
3.16	Operational Data Reporting	7.0
3.17	Grievances and Appeals	5.0
3.18	Payments To and From Plans	3.0
3.19	Financial Standards	2.0
3.20	Record Retention	2.0
3.21	Compliance	4.0
	Total Possible Technical Points	100.0
	Points for ISBE Participation	6.0
	Total Points	106.0

2. Readiness Review

For any successful Bidder, EOHHS will conduct a readiness review prior to the Operational Start Date in accordance with 42 CFR § 438.66(d)⁷⁸ to ensure the Bidder is prepared to perform the requirements of the Model Contract. EOHHS will provide successful Bidders with a Readiness Review Schedule with timelines for completing all Readiness Review activities. The successful Bidder must complete all Readiness Review activities to the satisfaction of EOHHS no later than sixty (60) calendar days prior to the Operational Start Date, or a delayed Operational Start Date may be required. EOHHS reserves the right to continue review activities after the Operational Start Date, at its discretion.

⁷⁸ 42 CFR § 438.66(d) - [https://www.ecfr.gov/current/title-42/part-438/section-438.66#p-438.66\(d\)](https://www.ecfr.gov/current/title-42/part-438/section-438.66#p-438.66(d))

