STATE OF MARYLAND

MARYLAND DEPARTMENT OF HEALTH (MDH)

REQUEST FOR PROPOSALS (RFP)

EXTERNAL QUALITY REVIEW OF THE MARYLAND HEALTHCHOICE PROGRAM

RFP NUMBER MDH OPASS #21-18957

ISSUE DATE: MAY 18, 2021

NOTICE

A Prospective Offeror that has received this document from a source other than eMarylandMarketplace (eMMA) https://procurement.maryland.gov should register on eMMA. See **Section 4.2**.

MINORITY BUSINESS ENTERPRISES ARE ENCOURAGED TO RESPOND TO THIS SOLICITATION.

VENDOR FEEDBACK FORM

To help us improve the quality of State solicitations, and to make our procurement process more responsive and business friendly, please provide comments and suggestions regarding this solicitation. Please return your comments with your response. If you have chosen not to respond to this solicitation, please email or fax this completed form to the attention of the Procurement Officer (see Key Information Summary Sheet below for contact information).

Title: External Quality Review of the Maryland HealthChoice Program
Solicitation No: MDH OPASS #21-18957

1. If you have chosen not to respond to this solicitation, please indicate the reason(s) below:

- ☐ Other commitments preclude our participation at this time
- ☐ The subject of the solicitation is not something we ordinarily provide
- ☐ We are inexperienced in the work/commodities required
- ☐ Specifications are unclear, too restrictive, etc. (Explain in REMARKS section)
- ☐ The scope of work is beyond our present capacity
- ☐ Doing business with the State is simply too complicated. (Explain in REMARKS section)
- ☐ We cannot be competitive. (Explain in REMARKS section)
- ☐ Time allotted for completion of the Proposal is insufficient
- ☐ Start-up time is insufficient
- ☐ Bonding/Insurance requirements are restrictive (Explain in REMARKS section)
- ☐ Proposal requirements (other than specifications) are unreasonable or too risky (Explain in REMARKS section)
- ☐ MBE or VSBE requirements (Explain in REMARKS section)
- ☐ Prior State of Maryland contract experience was unprofitable or otherwise unsatisfactory. (Explain in REMARKS section)
- ☐ Payment schedule too slow
- ☐ Other: _____

2. If you have submitted a response to this solicitation, but wish to offer suggestions or express concerns, please use the REMARKS section below. (Attach additional pages as needed.)

REMARKS:

_____

_____

Vendor Name: _____ Date: _____

Contact Person: _____ Phone (____) _____ - _____

Address: _____

E-mail Address: _____

STATE OF MARYLAND

MARYLAND DEPARTMENT OF HEALTH (MDH)

KEY INFORMATION SUMMARY SHEET

Request for Proposals	Services - External Quality Review of the Maryland HealthChoice Program
Solicitation Number:	MDH OPASS #21-18957
RFP Issue Date:	May 18, 2021
RFP Issuing Office:	Maryland Department of Health (MDH or the "Department")
Procurement Officer: **e-mail:** **Office Phone:**	Jim Beauchamp, Director Office of Procurement and Support Services Maryland Department of Health (MDH) 201 W. Preston Street, Room 416 B Baltimore, MD 21201 mdh.solicitationquestions@maryland.gov 410-767-5335
Contract Officer **e-mail:** **Office Phone:**	Calvin T. Johnson Office of Procurement and Support Services calvin.johnson@maryland.gov 410-767-8216
Proposals are to be sent to:	Proposals will be accepted through the State's eMaryland Marketplace Advantage (eMMA) e-Procurement system. Instructions on how to submit proposals electronically can be found at: https://procurement.maryland.gov/wp-content/uploads/sites/12/2019/08/5-eMMA-QRG-Responding-to-Solicitations-Double-Envelope-v2.pdf
Pre-Proposal Conference:	**Virtual Teleconference by Calendar Invitation from Procurement Officer Only** See **Attachment A** for instructions.
Questions Due Date and Time	July 9,2021 at 2:00 pm Local Time
Proposal Due (Closing) Date and Time:	July 16 ,2021 at 2:00 pm Local Time Offerors are reminded that a completed Feedback Form is requested if a no-bid decision is made (see **page iv**).
MBE Subcontracting Goal:	25%
VSBE Subcontracting Goal:	1%
Contract Type:	Definite Quantity Firm Fixed Price

Contract Duration:	Five (5) year base period with zero (0) option periods
Primary Place of Performance:	Will be proposed by Offeror.
SBR Designation:	No
Federal Funding:	Yes

TABLE OF CONTENTS - RFP

1 Minimum Qualifications

1.1 Offeror Minimum Qualifications

To be considered reasonably susceptible of being selected for award, the Offeror must document in its Proposal that, within the last seven (7) years, the following Minimum Qualifications have been met:

1.1.1 The Offeror will demonstrate that it meets the qualifications of an External Quality Review organization (EQRO; see Appendix 1) as set forth in 42 CFR 438.354.

Required Documentation: As proof of meeting this requirement, the Offeror will provide with its Proposal an attestation, signed by the organization's chief executive officer or its equivalent, that the organization meets each competence and independence requirement outlined in 42 CFR 438.354 (b) and (c). See section 5.3

1.1.2 The Offeror will be a federally designated Quality Improvement Organization (QIO) or QIO-like Entity as defined by the Centers for Medicare and Medicaid Services (CMS) (see Appendix 1).

Required Documentation: As proof of meeting this requirement, the Offeror will provide evidence of being selected through competitive procurement as a QIO by CMS or documentation of its designation as a QIO-like entity as an attachment to its Transmittal Letter (see section 5.3)

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

2 Contractor Requirements: Scope of Work

2.1 Summary Statement

2.1.1 The Maryland Department of Health (or MDH or the Department) is issuing this Request for Proposals (RFP) in order to select an external quality review organization to perform quality assurance activities for HealthChoice, Maryland's mandatory Medicaid managed care program. HealthChoice provides health care to most Medicaid participants. Eligible Medicaid participants enroll in a managed care organization (MCO) and select a primary care provider (PCP) to oversee their medical care.

2.1.2 It is the State's intention to obtain goods and services, as specified in this RFP, from a Contract between the selected Offeror and the State.

2.1.3 The Maryland Department of Health intends to make a single award as a result of this RFP. See RFP **Section 4.9 Award Basis** for more Contract award information.

2.1.4 An Offeror, either directly or through its subcontractor(s), must be able to provide all goods and services and meet all of the requirements requested in this solicitation and the successful Offeror (the Contractor) will remain responsible for Contract performance regardless of subcontractor participation in the work.

2.2 Background and Purpose

The State is issuing this solicitation for the purpose of contracting with an External Quality Review Organization (EQRO) who can successfully perform External Quality Review activities (See Appendix 1) for HealthChoice Managed Care Organizations (MCOs) (see Appendix 1) as described in 42 CFR 438.358. MDH is responsible for evaluating the quality of care provided to eligible participants by contracted MCOs through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice's guiding principle is to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost effective. In HealthChoice, MDH contracts with nine MCOs: Aetna Better Health of Maryland; AMERIGROUP Community Care; Jai Medical Systems, Inc.; Kaiser Permanente of the Mid-Atlantic States, Inc.; Maryland Physicians Care; MedStar Family Choice, Inc.; Priority Partners; UnitedHealthcare Community Plan; and University of Maryland Health Partners. The EQRO evaluates the MCOs in accordance with federal and State laws and regulations, policies, and guidelines. The EQRO also assesses whether HealthChoice achieves the goals outlined in its Quality Strategy.

The overall goals of MDH's Quality Strategy are to ensure compliance with changes in Federal and State laws and regulations affecting the Medicaid program; improve quality and health care performance continually using evidence–based methodologies for evaluation; compare Maryland's results to national and state performance benchmarks to identify areas of success and improvement; reduce administrative burden on MCOs and the program overall; and, assist MDH with setting priorities and responding to identified areas of concern within the HealthChoice participant population. MDH works collaboratively with MCOs and stakeholders to identify opportunities for improvement and to initiate quality improvement activities that will impact the quality of health care services for HealthChoice participants.

Mandatory EQRO activities include the Systems Performance Review, Performance Improvement Projects, Value-Based Purchasing, and Network Adequacy Assessments. Optional EQRO activities

include Encounter Data Validation; EPSDT/Healthy Kids Medical Record Reviews; Quarterly Review of Appeals, Grievances, and Pre-Service Denials; and the Consumer Report Card.

2.2.1 Project Goals

A. The EQRO assesses each MCO's strengths and weaknesses regarding the quality, timeliness, and access to health care services annually. The EQRO makes recommendations on how to improve the quality of health care services furnished by each MCO.

B. The EQRO provides recommendations to the Department about how to target goals and objectives to improve the quality, timeliness, and access to health care services for participants based on the assessments performed.

C. The EQRO presents the external quality review results and findings in an annual detailed technical report that is submitted to the Centers for Medicare and Medicaid Services and made publicly available.

2.2.2 Existing Reporting

A. Existing reporting related to the EQRO activities may be found at https://mmcp.health.maryland.gov/healthchoice/pages/HealthChoice-Quality-Assurance-Activities.aspx.

2.2.3 State Staff and Roles

MDH's Medical Benefits Management Administration (MBMA) is responsible for oversight of the HealthChoice program. MBMA ensures that the MCOs are in compliance with the initiatives established in 42 CFR 438, Subpart D. The Division of HealthChoice Quality Assurance within MBMA is primarily responsible for monitoring the quality activities involving external quality review and Centers for Medicare and Medicaid Services (CMS) quality improvement requirements for the HealthChoice program. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care oversight process.

In addition to the Procurement Officer and Contract Monitor, the following staff will oversee the EQRO conducting all project activities and tasks to ensure all goals are met and all deliverables are successfully completed on-time per all requirements noted in this RFP:

A. Contract Monitor

1. The Contract Monitor for this Contract is Stephanie Boyd, who serves as the Division Chief for HealthChoice Quality Assurance within the Medical Benefits Management Administration.
2. The Contract Monitor will serve as the main point of contact for the Contractor. The Contractor shall direct questions related to compliance with this Contract, submissions of deliverables, and any other issues related to the Contract to the Contract Monitor.
3. She is primarily responsible for Contract administration functions, including issuing written direction, invoice approval, monitoring this Contract to ensure compliance with the terms and conditions of the

Contract, monitoring MBE and VSBE compliance, and achieving completion of the Contract on budget, on time, and within scope. The Maryland Department of Health may change the Contract Monitor at any time by written notice to the Contractor

B. EQRO Lead

1. The State will provide an EQRO Lead within the Division of HealthChoice Quality Assurance to assist the Contract Monitor with managing daily communications and review of deliverables as a secondary point of contact.
2. The EQRO Lead reports to the Division of HealthChoice Quality Assurance and assists with responding to EQRO questions, overseeing contract activities, reviewing deliverables, and making recommendations to improve the quality assurance activities performed by the Contractor.

2.2.4 Other State Responsibilities

The State is responsible for facilitating the provision of required information, data, documentation, and test data to facilitate the Contractor's performance of the work, and will provide such additional assistance and services as is specifically set forth.

2.3 Responsibilities and Tasks

2.3.1 Systems Performance Review-Assessment of Compliance with Medicaid Managed Care Regulations

A. The Contractor will perform the Systems Performance Review (SPR) (see Appendix 1) to assess each HealthChoice MCO's compliance with federal and Maryland laws and regulations. This assessment includes determining the adequacy and effectiveness of the MCO's operational infrastructure and evaluating the Quality of services provided to Medicaid Participants (see Appendix 1). Prior to 2016, the Department required this assessment annually. The SPR performed under this Contract will occur on a three-year cycle.

B. Unless otherwise specified by the Contract Monitor, the full SPR will be conducted for calendar year 2021 and will be reviewed in Calendar Year 2022. This SPR will be a comprehensive review of all standards.

1. The Contractor will conduct annual intermediate desktop or onsite follow-up reviews for MCOs receiving partially met or unmet findings from the previous SPR to determine compliance with stated Corrective Action Plans (see Appendix 1).
2. The Contractor will conduct desktop reviews for baseline standards introduced during a year that does not coincide with the comprehensive review year (2021), as applicable.
3. The Contractor will issue an assessment report, recommendations, and/or additional Corrective Action Plans resulting from intermediate or baseline reviews, as applicable.
4. The Contractor will offer technical assistance to MCOs to resolve deficiencies as needed.

C. The Contractor will develop a protocol and timeline for the SPR consistent with CMS EQR Protocol 3: Review of Compliance with Medicaid Managed Care Regulations and its attachments (Appendix 3).

1. The Contractor will be responsible for ensuring its protocol remains compliant with any changes to the CMS EQR Protocol and COMAR regulations.

2. The protocol and timeline will be subject to approval by the Contract Monitor.

D. The Contractor will develop a timeline for initiation, performance, and completion of all SPR activities (i.e., full and intermediate reviews). The timeline will conclude with the issuance of the final audit reports to the MCOs and to the Contract Monitor by May 31 of the Contract year or a timeframe otherwise specified by the Contract Monitor. The timeline should account for the following activities:

1. Obtaining Contract Monitor approval for preliminary and final audit reports;

2. Submitting preliminary reports to the MCOs for review and comment; and,

3. Receiving Corrective Action Plans from the MCOs for analysis and inclusion into the final reports.

E. The Contractor will submit to the Contract Monitor for approval any recommended updates or revisions to the SPR review criteria annually from July 1 to August 31 of each Contract Year of Contract Transition.

1) The Contract Monitor and the Contractor will collaborate on any substantive updates to the SPR review criteria.

2) The Contractor will prepare a crosswalk of SPR review criteria to National Committee for Quality Assurance (NCQA) Accreditation standards (see Appendix 1) to determine which SPR review criteria are eligible for Deeming (see Appendix 1), in accordance with when each MCO has received NCQA accreditation

3) The Contract Monitor will have final approval of all SPR review criteria and all deemed standards.

4) The approved criteria will be provided in an orientation manual that will be distributed by the Contractor to the MCOs at the annual September Quality Assurance Liaison Committee (QALC) meeting (see Appendix 1 and section 2.4).The current standards for the 2019 SPR are included in Appendix 5.

F. Prior to the SPR onsite review, the Contractor will obtain information from each MCO consisting of at least a pre-site survey, and all applicable written plans, policies, and procedures for a desktop review. Deadlines for submitting information for the pre-site survey and conducting the desktop review will be included in the timeline in 2.3.1.

G. After the desktop review is complete, the Contractor will schedule a two- to three-day onsite review with each MCO at the administrative office of the MCO's choosing. The onsite review will conclude with an exit interview that provides the MCO with a significant review finding, probable areas of non-compliance, and

possible areas that can be clarified or corrected with the provision of additional information by the MCO.

H. The Contractor will send a letter identifying all areas of non-compliance or requests for additional information within 10 Business Days (see Appendix 1) of the review and permit the MCO 10 Business Days to respond to the letter. Each letter will be reviewed and approved by the Contract Monitor.

I. The Contractor will develop a preliminary report of findings for each MCO, with each report subject to approval by the Contract Monitor.

1. After Contract Monitor approval and preliminary report distribution, the Contractor will extend the option to each MCO to discuss the preliminary report's findings, in a time frame established by the Contractor and the Contract Monitor.
2. The discussion may be held by phone at the MCO's option.
3. The Contractor will inform each MCO when Corrective Action Plans are due, if applicable, at the conclusion of the discussion.

J. The Contractor will collect, review, and evaluate all complete Corrective Action Plans within 10 Business Days of submission by the MCO. The Contractor will include approved Corrective Action Plan information in each MCO's final report.

K. The Contractor will include the following information in its final report for each MCO:

1. Objective, technical methods of data collection and analysis, and data obtained for each Contract activity;
2. Conclusions drawn from the data, including assessment of MCO strengths and weaknesses with respect to the timeliness, access, and quality of health care services furnished to recipients;
3. Recommendations for improving compliance;
4. Assessment of MCO's Corrective Action Plans submitted after receiving the draft report; and,
5. Assessments of the implementation of the MCO's Corrective Action Plan from the previous SPR and any intermediate reviews.

L. The Contractor will maintain documentation of all aspects of the SPR and make this information available to the Contract Monitor.

1. The Contractor's documentation will be sufficiently detailed to allow the Contract Monitor and/or subsequent Contractors to understand the work performed, the evidence obtained, and how conclusions were reached.
2. The Contractor's documentation will be well-organized, adequately cross-referenced between report results and supporting documentation, and sufficiently detailed to create a comprehensive and complete record of activities performed.
3. The Contractor will include trending analysis for each MCOs performance of the SPR by standard element and component.

M. The Contractor will incorporate the results, findings, and recommendations of the SPR into the Annual Technical Report (ATR) (see Appendix 1 and 2.3.9). The report will include trends across all MCOs and trends specific to each MCO.

2.3.2 Validation of Performance Measures

A. Value Based Purchasing Initiative Performance Measures

1) To validate the Value Based Purchasing Initiative (VBPI; see Appendix 1) Performance Measures, the Contractor will develop and submit the following for approval by the Contract Monitor:

a) A work plan for all Validation activities (see Appendix 1) that is consistent with CMS EQR Protocol 2: Validation of Measures Reported by the MCO (Appendix 3)

b) A timeline for the initiation, performance, and completion of the validation, including submission of draft reports for review and comment by the Contract Monitor prior to report finalization.

c) Templates of the required draft and final reports of MCO performance, including an Executive Summary.

2) The Contractor will be responsible for ensuring its protocol remains complaint with any changes to the CMS EQR Protocol and COMAR (see Appendix 1).

3) The Contractor will work directly with the Contract Monitor's other contractors who perform HEDIS® validation and encounter data analysis in order to obtain needed information on VBPI Performance Measures.

4) The final report for VBPI Performance Measures utilizing the approved report template is due by November 15 of the year following the reporting period.

5) The Contractor will incorporate the results and findings of the VBPI final reports into the ATR.

B. Other Performance Measures Designed by the Department

1) The Contractor will be responsible for validating any additional performance measures designed by the Department for other health care initiatives.

2) The Contractor will provide the results and findings to the Contract Monitor.

3) The Contractor may incorporate the results and findings of other performance measures into the ATR.

2.3.3 Development and Validation of Performance Improvement Projects (PIPs)

A. Performance Improvement Projects (PIPs; see Appendix 1) typically runs on a cycle of three years. For the PIPs, the Contractor will:

1) Develop and submit for approval by the Department a protocol for validating each PIP. The protocol will meet the requirements of CMS EQR Protocol 2: Validating Performance Improvement Projects (Appendix 3).

2) Provide technical assistance to the MCOs using CMS EQR Protocol 8: Implementation of Performance Improvement Projects (Appendix 3)

3) Provide any necessary training on project implementation measures and project design.

4) Ensure its protocol remains compliant with any changes to the CMS EQR Protocol.

5) Work with the MCOs to develop a timeline for all PIP activities to be conducted by the MCO and for the Contractor to validate the results.

6) Develop a timeline for the initiation, performance, and completion of PIP Validation, including submission of reports for review and approval by the Contract Monitor, which ends no later than October 31 of each Contract year.

7) Develop a template by September 1 for the following reports to be written and submitted to the Contract Monitor:

a) MCO PIP Project Update (Due by September 30 of each contract year);

b) Annual PIP Updates (due by December 31 of each contract year); and,

c) Final PIP Report (due within 30 days of the completion of PIP Cycle).

8) Provide technical assistance to the Contract Monitor throughout the selection, development, and implementation of each PIP cycle.

B. The Contractor will submit each PIP report referenced in 2.3.3 to the Contract Monitor with a submission deadline to be determined by the Contract Monitor consultation with the Contractor. The Contractor must receive the CMS's approval before a report is accepted as complete.

C. The Contractor will incorporate the results, findings, and recommendations of the annual and final PIP reports into the ATR.

2.3.4 Network Adequacy Assessments

A. The Contractor will perform a network adequacy validation annually to determine each MCO's compliance with federal and State standards and regulations.

B. The network adequacy validation will include but not be limited to:

1) Telephone calls to determine the accuracy of network information maintained by MCOs.

2) Telephone calls to providers to assess compliance with wait times for routine and urgent appointments.

3) Accuracy of provider information in each MCO's online provider directory in accordance with COMAR 10.67.05.02C.

C. Unless and until further guidance is issued by CMS in a future EQR protocol addressing network adequacy validation, the Contractor will model its network adequacy validation on the example provided in Appendix 3.

D. With approval of the Contract Monitor, the Contractor will develop and implement the study design, timelines, materials, sampling methodologies, analysis methodologies, and reporting templates.

E. The Contractor will obtain and validate the network information required to conduct the study from the Contract Monitor and the MCOs.

F. After the studies are conducted, the Contractor will analyze the results and identify areas of compliance and non-compliance for each MCO in a detailed report of findings.

1) The Contractor will recommend Corrective Action Plans for MCOs with areas of non-compliance.

2) The Contractor will review and evaluate all Corrective Action Plans submitted by MCOs for areas of non-compliance.

3) The Contractor will include Corrective Action Plan information in the final report and prepare trending reports to show year over year compliance and non-compliance for the MCOs.

4) The Contract Monitor will review and approve reports related to the network adequacy validation.

G. The Contractor will maintain documentation of all aspects of the network adequacy validation and make this information available to the Contract Monitor.

1) The Contractor's documentation will be sufficiently detailed to allow the Department, CMS, and subsequent Contractors to understand the work performed, the evidence obtained, and how conclusions were reached.

2) The Contractor's documentation will be well-organized, adequately cross-referenced between report results and supporting documentation, and sufficiently detailed to create a comprehensive and complete record of activities performed.

H. The Contractor will submit to the Contract Monitor final reports compiling the results of the studies annually, with a submission deadline to be determined by the Contract Monitor in consultation with the Contractor.

I. An executive summary highlighting the results of the studies will be included in the ATR.

2.3.5 Consumer Report Card

A. The Contractor will develop a methodology and design to produce a draft Consumer Report Card (CRC; Appendix 1) document annually. The methodology and design will be subject to approval by the Contract Monitor. The current CRC methodology is included as Appendix 6.

B. The Contract Monitor will have final approval of all aspects of the CRC, including proper translation into Spanish. The current CRC is provided in English and Spanish. See Appendix 3.

C. The Contractor will ensure the annual CRC uses the most currently available HEDIS® and CAHPS® data (see Appendix 1) by coordinating with the Department's NCQA-certified HEDIS® Compliance Auditor and NCQA-certified Survey Vendor.

D. The CRC will be made available in .pdf format no later than January 31st of each calendar year.

E. The Contractor will work with the Department to provide a high-resolution copy of the CRC for inclusion in enrollment packets, which will be printed and distributed to potential Participants.

F. A summary of the methodology and the final CRC will be included in the ATR.

G. Should the Medicaid quality rating system under 42 CFR 438.334 become effective during the term of the Contract, the Contractor will assist the Department with compliance at no additional cost.

2.3.6 Encounter Data Validation

A. For the Encounter Data Validation (EDV; see Appendix 1), the Contractor will:

1) Conduct an annual EDV audit to verify the accuracy of encounter data compared to the rendering provider's medical record.

2) The Contractor will develop and submit a protocol for EDV for Department approval. The protocol will meet the requirements of CMS EQR Protocol 5: Validation of Encounter Data Reported by the Medicaid and Managed Care Plan (Appendix 3).

3) The Contractor will be responsible for ensuring its protocol remains compliant with any changes to the CMS EQR Protocol. The Contractor is responsible for activities 1, 2, 4, and 5. Activity 3 is completed by a different vendor. The Contractor is required to coordinate with the Department's vendor and integrate the findings for Activity 3 into the EDV report.

4) The Contractor will develop a timeline and report templates for conducting the EDV and submit it for Department approval.

5) The Contractor will receive a randomly selected sample of encounters from the Department's data warehouse vendor, The Hilltop Institute at University of Maryland, Baltimore County.

a) The sampling will include practitioner and institutional encounters.

b) The percentages of each encounter type will be determined by the Department.

6) The Contractor will contact the providers and arrange for completion of the medical record reviews. Contacts will include two mailed or electronic requests and phone follow-up to non-responders.

7) The Contractor will make reasonable efforts to complete all reviews to yield a statistically significant sample of encounters.

B. The Contractor will submit a final report to the Department for approval that includes the scope of the EDV and the analysis results, due by November 30 of each Contract year.

C. The Contractor will incorporate the results, findings, and recommendations of the EDV into the ATR.

2.3.7 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthy Kids Review

A. The Contractor will collect and analyze data that provides an annual assessment of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT; see Appendix 1) services provided to Participants (see Appendix 1) less than 21 years of age served by MCOs.

B. With the approval of the Contract Monitor, the Contractor will review and update the standards to complete the annual assessment. The current standards are in Appendix 4.

C. To maintain consistency with the review standards of the Department, the Contractor will participate in an orientation and training session in conjunction with the Department's Division of Children's Services no later than April 30 of each Contract year.

D. Using the information from the training and orientation, the Contractor will independently assess inter-rater reliability of the Contractor's staff and achieve individual scores of at least 90%.

E. The Contractor will review a statistically valid sample of primary care medical records of HealthChoice Participants for each MCO. This review will determine provider compliance with the Maryland Healthy Kids Preventive Health Schedule (Appendix 3).

F. The Contractor will contact providers via mail, phone, and/or email to arrange appointments to conduct the record reviews in the providers' offices or for providers to electronically transmit medical records securely to the Contractor. Correspondence to arrange these reviews is subject to Contract Monitor approval.

G. The Contractor will produce reports of the aggregate results and individual review results by MCO. The Contract Monitor will approve all reports and reporting templates within timeframes outlined in 2.4.4

H. The Contractor will summarize the aggregate and individual review results for inclusion in the ATR.

2.3.8 Quarterly Analysis of Pre-Service Authorizations, Appeals, and Grievances

A. The Contractor will on a quarterly basis determine MCO compliance with appropriate denials of service preauthorizations and appropriate handling of appeals and grievances. The reporting instructions and templates for MCO submission of this information are in Appendix 3.

B. The Contractor will coordinate informational meetings with the MCOs about report submission guidelines, data trends, and feedback on the submission process.

C. The Contractor will use EQR Protocol 9: Conducting Focused Studies of Health Care Quality (Appendix 3) to guide implementation and design.

D. The Contractor will be responsible for ensuring its protocol remains compliant with any changes to the CMS EQR Protocol.

E. The Contractor will model its initial quarterly analysis on the example linked in Appendix 3.

F. With approval from the Contract Monitor, the Contractor will develop the study design, timelines, materials, sampling methodologies, analysis methodologies, and reporting templates.

G. The Contractor will work in conjunction with the Contract Monitor and/or the MCOs to obtain and validate the information required to conduct the studies in accordance with their designs.

H. On a quarterly basis, the Contractor will analyze the results and identify all areas of compliance and non-compliance. The Contractor will meet with the Department on a quarterly basis to discuss MCO submissions, data analysis, recommendations, and all noncompliant areas.

I. In an annual report of findings, the Contractor will summarize the quarterly analysis, including areas of compliance and non-compliance, for each MCO. The Contract Monitor will review and approve all reports.

J. The Contractor will maintain documentation of all aspects of the studies and make this information available to the Contract Monitor.

1) The Contractor's documentation will be sufficiently detailed to allow the Contract Monitor and/or subsequent Contractors to understand the work performed, the evidence obtained, and how conclusions were reached.

2) The Contractor's documentation will be well-organized, adequately cross-referenced between report results and supporting documentation, and sufficiently detailed to create a comprehensive and complete record of activities performed.

K. The Contractor will submit to the Contract Monitor final reports compiling the results of the studies annually, with a deadline to be determined by the Contract Monitor in consultation with the Contractor.

2.3.9 Annual Technical Report (ATR) 42 CFR §438.364)

A. The Contractor will produce a final ATR that describes the manner in which the data from all activities conducted were aggregated and analyzed, and the way in which conclusion were drawn as to the timeliness, quality, and access to the care provided by the MCO for the Maryland HealthChoice Program. The link to the current ATR is included in Appendix 3.

B. For each EQR activity conducted, the ATR will include objective, technical methods of data collection and analysis, description of data obtained, conclusions drawn from data, and recommendations for program improvement.

C. The Contractor will follow the formatting requirements for the ATR set forth in Section 508 of the Rehabilitation Act (29 USC §794d). The Contractor will attempt to limit the body of the report to less than 50 pages and to represent findings in tabular and graphic formats.

D. The Contractor will finalize the ATR for data collected within the prior 24 months by April 30th of each year.

2.3.10 Technical Assistance

A. MCO Technical Assistance

1) For the activities outlined in this contract, the Contractor will provide technical assistance to each participating HealthChoice MCO.

2) In the event an MCO applies to participate in the HealthChoice program, the Contractor will provide technical assistance to the MCO applicant concerning the SPR standards and guidelines, upon request of the Department.

B. Medical Record Review for Complaint Resolution Unit

1) The Contractor will provide medical case reviews to determine medical necessity of Services to aid the Department's Complaint Resolution Unit on an ad hoc basis.

2) This assistance may include, on rare occasions, attending a formal appeal hearing and giving expert testimony on behalf of the Department.

3) The Department estimates that the Contractor will receive no more than 20 cases a year for review.

C. Technical Assistance to the Department

1) Upon request, the Contractor will provide advice to the Department about other relevant inquiries and initiatives related to quality improvement.

2) The Contractor may provide recommendations to the Department about improvement of its quality activities on an ad hoc basis.

2.3.11 Continuity of Operations Plan (COOP)

A. The Contractor will have a Continuity of Operations Plan that includes:

1. Procedures for alerting, notifying, activating, and deploying employees
2. Identifying critical business functions
3. Establishing an alternate facility and/or remote work protocols
4. Guidelines for system operations and system accessibility
5. A personnel roster with authority and knowledge of functions of the Contractor's organization
6. Guidelines to stay in communication with the Department and the MCOs
7. Process to continue project tasks, make recommendations, and/or postpone any affected activities.

B. The COOP developed by the contractor must ensure its operations are performed efficiently and with minimal disruption, especially during an emergency.

C. The Contractor will provide the Department with a COOP at the start of the contract period.

D. The Contractor will be responsible for updating the COOP at least annually and providing a copy to the Department upon request.

2.3.12 Contractor-Supplied Hardware, Software, and Materials

A. The Contractor will establish and maintain a secure portal for coordinating all quality assurance activities between itself, the State, and the MCOs. This portal must comply with all federal and State privacy laws and regulations, store all information related to contract deliverables, and serve as a resource for the State and MCOs about the EQR process.

B. SaaS applications will be accessible from various client devices through a thin client interface such as a Web browser (e.g., Web-based email) or a program interface.

C. The State will be permitted limited user-specific application configuration settings.

D. The Contractor is responsible for the acquisition and operation of all hardware, software and network support related to the services being provided, and will keep all software current.

E. All Upgrades and regulatory updates will be performed at no additional cost.

F. Hardware and software costs procured as part of the RFP cannot exceed 49 percent of the total Contract value.

G. Material costs will be passed through with no mark-up by the Contractor.

2.3.13 Required Project Policies, Guidelines and Methodologies

The Contractor will be required to comply with all applicable laws, regulations, policies, standards, and guidelines affecting Information Technology projects, which may be created or changed periodically. Offeror is required to review all applicable links provided below and state compliance in its response.

It is the responsibility of the Contractor to ensure adherence and to remain abreast of new or revised laws, regulations, policies, standards, and guidelines affecting project execution. These include, but are not limited to:

A. The State of Maryland System Development Life Cycle (SDLC) methodology at: http://doit.maryland.gov/SDLC/Pages/agile-sdlc.aspx ;;

B. The State of Maryland Information Technology Security Policy and Standards at: http://www.DoIT.maryland.gov- keyword: Security Policy;

C. The State of Maryland Information Technology Non-Visual Standards at: http://doit.maryland.gov/policies/Pages/ContractPolicies.aspx.

D. The 2019 CMS External Quality Review Protocols at:

https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

E. The HealthChoice Managed Care Organization Agreement

https://mmcp.health.maryland.gov/healthchoice/Documents/MCO%20Agreement%202020.pdf

2.3.14 Product Requirements

A. Offerors may propose open source software; however, the Offeror must provide operational support for the proposed software as part of its Proposal.

B. Offeror will be authorized to furnish the proposed goods and services.

C. No international processing for State Data: As described in **Section 3.7 Security Requirements**, Offerors are advised that any processing or storage of data outside of the continental U.S. is prohibited.

D. Any Contract award is contingent on the State's agreement, during the Proposal evaluation process, to any applicable terms of use and any other agreement submitted under **Section 5.3.2.** Such agreed upon terms of use will apply consistently across services ordered under the Contract.

E. The Contractor will not establish any auto-renewal of services beyond the period identified in Contract documents.

F. In addition to any notices of renewal sent to the Department, Contractors will email notices of renewal to the e-mail address designated by the Contract Monitor.

2.3.15 Maintenance and Support

Maintenance and support, and Contractor's ongoing maintenance and support obligations, are defined as follows:

A. Operations tasks to include virus scans

B. Activity reporting

C. User support (Help Desk)

1. Contractor will furnish Help Desk services for the secure, HIPAA compliant portal used to house information related to EQR activities.
2. Help Desk services are available during Normal State Business Hours.
3. Contractor will utilize a help desk ticketing system to record and track all help desk calls. The ticketing system will record with a date and timestamp when the ticket was opened and when the ticket was closed.

2.3.15.1 Technical Support

A. "Technical Support" means Contractor-provided assistance for the services or Solution furnished under the Contract, after initial end-user support confirms a technical issue that requires additional troubleshooting capabilities; sometimes referenced as Tier II – IV support.

B. Technical Support will be available during Normal State Business Hours.

C. The State will be able to contact a Technical Support team member during Normal State Business Hours.

D. Contractor Personnel providing technical support will be familiar with the State's account (i.e., calls will not be sent to a general queue).

E. Contractor will return calls for service of emergency system issues (see Section 2.5 Service Level Agreement) within one (1) hour.

F. Calls for non-emergency IT service requests will be returned within three (3) hours or immediately the following day if after Normal State Business Hours.

G. The State will be provided with information on software problems encountered at other locations, along with the solution to those problems, when relevant to State software.

2.3.16 Backup

The Contractor will:

A. Perform backups of the web, application, and database servers on a regular basis. This will include daily incremental backups and full weekly backups of all volumes of servers;

B. Retain daily backups for one (1) month and weekly backups will be retained for two (2) years;

C. Store daily backups off-site.

D. Maintain one annual backup for at least 10 years;

E. Encrypt the backups using a shared key;

F. Perform a backup recovery at least semi-annually; and

G. Provide on demand support for the State's recovery of a backup set.

2.4 Deliverables

2.4.1 Deliverable Submission

A. For every deliverable, the Contractor will request the Contract Monitor confirm receipt of that deliverable by sending an e-mail identifying the deliverable name and date of receipt.

B. Unless specified otherwise, written deliverables will be compatible with Microsoft Office within two (2) versions of the current version. At the Contract Monitor's discretion, the Contract Monitor may request up to five (5) hard copies of written deliverables.

C. A standard deliverable review cycle will be elaborated and agreed-upon between the State and the Contractor. This review process is entered into when the Contractor completes a deliverable.

D. For any written deliverable, the Contract Monitor may request a draft version of the deliverable to comply with the minimum deliverable quality criteria listed in Section 2.4.3 Minimum Deliverable Quality. Drafts of each final deliverable, except status reports, are required at least two weeks in advance of when the final deliverables are due (with the exception of deliverables due at the beginning of the project where this lead time is not possible, or where draft delivery date is explicitly specified). Draft versions of a deliverable will comply with the minimum deliverable quality criteria listed in Section 2.4.3 Minimum Deliverable Quality.

2.4.2 Deliverable Acceptance

A. A final deliverable will satisfy the scope and requirements of this RFP for that deliverable, including the quality and acceptance criteria for a final deliverable as defined in **Section 2.4.4 Deliverable Descriptions/Acceptance Criteria**.

B. The Contract Monitor will review a final deliverable to determine compliance with the acceptance criteria as defined for that deliverable. The Contract Monitor is responsible for coordinating comments and input from various team members and stakeholders. The Contract Monitor is responsible for providing clear guidance and direction to the Contractor in the event of divergent feedback from various team members.

C. The Contract Monitor will issue to the Contractor a notice of acceptance or rejection of the deliverable.

D. In the event of rejection, the Contract Monitor will formally communicate in writing any deliverable deficiencies or non-conformities to the Contractor, describing in those deficiencies what will be corrected prior to acceptance of the deliverable in sufficient detail for the Contractor to address the deficiencies. The Contractor will correct deficiencies and resubmit the corrected deliverable for acceptance within the agreed-upon time period for correction.

2.4.3 Minimum Deliverable Quality

The Contractor will subject each deliverable to its internal quality-control process prior to submitting the deliverable to the State.

Each deliverable will meet the following minimum acceptance criteria:

A. Be presented in a format appropriate for the subject matter and depth of discussion.

B. Be organized in a manner that presents a logical flow of the deliverable's content.

C. Represent factual information reasonably expected to have been known at the time of submittal.

D. In each section of the deliverable, include only information relevant to that section of the deliverable.

E. Contain content and presentation consistent with industry best practices in terms of deliverable completeness, clarity, and quality.

F. Meets the acceptance criteria applicable to that deliverable, including any State policies, functional or non-functional requirements, or industry standards.

G. Contains no structural errors such as poor grammar, misspellings or incorrect punctuation.

H. Must contain the date, author, and page numbers. When applicable for a deliverable, a revision table must be included.

I. A draft written deliverable may contain limited structural errors such as incorrect punctuation and will represent a significant level of completeness toward the associated final written deliverable. The draft written deliverable will otherwise comply with minimum deliverable quality criteria above.

2.4.4 Deliverable Descriptions/Acceptance Criteria

In addition to the items identified in the table below, the Contractor may suggest other subtasks, artifacts, or deliverables to improve the quality and success of the assigned tasks.

Deliverables Summary Table*

ID #	Deliverable Description	Acceptance Criteria	Due Date / Frequency
3.1	Integrated Project Schedule	Microsoft Project schedule demonstrating tasks, task estimates, resource assignments, and dependencies for both Agency and Contractor Personnel, with tasks no less than 8 hours and no greater than 80 hours.	Initial Delivery: NTP+ 10 Business Days Updates: Weekly
2.3.1	Development and Finalization of SPR Orientation Manual (Section 2.3.1)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Starts no later than July 1 and concludes no later than August 31
2.3.1	SPR Onsite Reviews (Section 2.3.1)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Starts no later than January 1 and concludes no later than February 28/29

2.3.1	Development and Finalization of SPR Preliminary Report (2.3.1)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Development no later than March 1 Finalization of preliminary report no later than March 31
2.3.1	Completion of SPR Final Report (Section 2.3.1)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	May 31
2.3.1	Completion of SPR Executive Summary (Section 2.3.1)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	June 30
2.3.2	Completion of VBPI Executive Summary (Section 2.3.2)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	December 31
2.3.7	Finalization of EPSDT/Healthy Kids Review Preliminary Findings (Section 2.3.7)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	February 28/29
2.3.7	Development of EPSDT/ Healthy Kids Review Preliminary Findings (Section 2.3.7)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Development no later than August 1 Preliminary findings report issued no later than September 30

2.3.7	Completion of EPSDT/Healthy Kids Review Executive Summary and Final Reports (Section 2.3.7)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	October 31
2.3.3	Review and Completion of PIP Annual Submissions (Section 2.3.3)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Final Annual Submission completion no later than September 30
2.3.3	Review and completion of Annual PIP Validations (Section 2.3.3)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Review beginning no later than October 1 Final report completion no later than November 30
2.3.3	Completion of PIP Annual Reports (Section 2.3.3)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	December 31
2.3.6	Development of EDV Draft Report (Section2.3.6)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	November 30
2.3.6	Completion of EDV Final Report (Section 2.3.6)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	January 31
2.3.5	Issuance of CRC (Section 2.3.5)	All deliverables from the EQRO to the	January 31

		Department must comply with all the applicable criteria found in section 2.4 and section 2.3	
2.3.9	Development and Completion of ATR Draft (Section 2.3.9)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Development no later than February 1 Completion no later than April 15
2.3.4	Annual Network Adequacy Assessments (Section 2.3.4)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Project deliverables fates to be determined by Contract Monitor and Contractor, with final authority resting with the Contract Monitor
2.3.8	Quarterly and Annual Pre-Service Denial Report and Appeals and Grievances Reports (Section 2.3.8)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	Projected deliverables dates to be determined by Contract Monitor and Contractor, with final authority resting with the Contract Monitor.
2.3.11	Continuity of Operations Plan (COOP)	All deliverables from the EQRO to the Department must comply with all the applicable criteria found in section 2.4 and section 2.3	As outlined in the scope of work

*The deliverables summary table may not list every contractually-required deliverable. Offerors and Contractors should read the RFP thoroughly for all Contract requirements and deliverables.

2.5 Service Level Agreement (SLA)

2.5.1 Definitions

A. A “Problem” is defined as any situation or issue reported via a help desk ticket that is related to the system operation that is not an enhancement request.

B. “Problem resolution time” is defined as the period of time from when the help desk ticket is opened to when it is resolved.

C. Monthly Charges: for purposes of SLA credit calculation, Monthly Charges are defined as the charges set forth in Attachment B, Financial Proposal Form, invoiced during the month of the breach for the monthly fixed services, or, in the event of annual billing, 1/12 of the annual invoice amount Financial Proposal Form.

2.5.2 SLA Requirements

The Contractor will:

A. Be responsible for complying with all performance measurements, and will also ensure compliance by all subcontractors.

B. Meet the Problem response time and resolution requirements as defined in **Section 2.5.5**

C. Provide a monthly report to monitor and detail response times and resolution times.

D. Log Problems into the help desk software and assign an initial severity (Emergency, High, Medium or Low as defined in **Section 2.5.5**.

E. Respond to and update all Problems, including recording when a Problem is resolved and its resolution. Appropriate Department personnel will be notified when a Problem is resolved.

F. The Department will make the final determination regarding Problem severity.

G. Contractor will review any Problem with Department to establish the remediation plan and relevant target dates.

2.5.3 SLA Effective Date (SLA Activation Date)

SLAs set forth herein will be in effect beginning with the commencement of monthly services as of the completion of the Transition-In Period.

2.5.4 Service Level Reporting

A. Contractor performance will be monitored by the Department.

B. The Contractor will provide detailed monthly reports evidencing the attained level for each SLA.

C. The Contractor will provide a monthly summary report for SLA performance.

D. Monthly reports will be delivered via e-mail to the Contract Monitor by the 15th of the following month.

E. If any of the performance measurements are not met during the monthly reporting period, the Contractor will be notified of the standard that is not in compliance.

3 Contractor Requirements: General

3.1 Contract Initiation Requirements

A. Contractor will schedule and hold a kickoff meeting within 10 Business Days of NTP Date. At the kickoff, the Contractor will furnish an updated Project Schedule and Work Plan describing the activities for the Contractor and the State.

B. Contractor will create, implement, and test its secure web portal by the Contract Start Date.

C. Contractor will hire all necessary staff and subcontractors to perform the duties of the Contract by the Contract Start Date.

3.2 End of Contract Transition

3.2.1 The Contractor will provide transition assistance as requested by the State to facilitate the orderly transfer of services to the State or a follow-on contractor, for a period up to 120 days prior to Contract end date, or the termination thereof. Such transition efforts will consist, not by way of limitation, of:

A. Provide additional services and support as requested to successfully complete the transition;

B. Maintain the services called for by the Contract at the required level of proficiency;

C. Provide updated System Documentation (see Appendix 1), as appropriate; and

D. Provide current operating procedures (as appropriate).

3.2.2 The Contractor will work toward a prompt and timely transition, proceeding in accordance with the directions of the Contract Monitor. The Contract Monitor may provide the Contractor with additional instructions to meet specific transition requirements prior to the end of the Contract.

3.2.3 The Contractor will ensure that all necessary knowledge and materials for the tasks completed are transferred to the custody of State personnel or a third party, as directed by the Contract Monitor.

3.2.4 The Contractor will support end-of-Contract transition efforts with technical and project support to include but not be limited to:

A. The Contractor will provide a draft Transition-Out Plan 120 Business Days in advance of Contract end date.

B. The Transition-Out Plan will address at a minimum the following areas:

1. Any staffing concerns/issues related to the closeout of the Contract;
2. Communications and reporting process between the Contractor, the Department and the Contract Monitor;
3. Security and system access review and closeout;
4. Any hardware/software inventory or licensing including transfer of any point of contact for required software licenses to the Department or a designee;
5. Any final training/orientation of Department staff;

6. Connectivity services provided, activities and approximate timelines required for Transition-Out;
7. Knowledge transfer, to include:
    a) A working knowledge of the current system environments as well as the general business practices of the Department;
    b) Review with the Department the procedures and practices that support the business process and current system environments;
    c) Working knowledge of all technical and functional matters associated with the Solution, its architecture, data file structure, interfaces, any batch programs, and any hardware or software tools utilized in the performance of the Contract;
    d) Documentation that lists and describes all hardware and software tools utilized in the performance of the Contract;
    e) A working knowledge of various utilities and corollary software products used in support and operation of the Solution;
8. Plans to complete tasks and any unfinished work items (including open change requests, and known bug/issues); and
9. Any risk factors with the timing and the Transition-Out schedule and transition process. The Contractor will document any risk factors and suggested solutions.

C. The Contractor will ensure all documentation and data including, but not limited to, System Documentation and current operating procedures, is current and complete with a hard and soft copy in a format prescribed by the Contract Monitor.

D. The Contractor will provide copies of any current daily and weekly back-ups to the Department or a third party as directed by the Contract Monitor as of the final date of transition, but no later than the final date of the Contract.

E. Access to any data or configurations of the furnished product and services will be available after the expiration of the Contract as described in Section 3.2.5.

3.2.5 Return and Maintenance of State Data

A. Upon termination or the expiration of the Contract Term, the Contractor will: (a) return to the State all State data in either the form it was provided to the Contractor or in a mutually agreed format along with the schema necessary to read such data; (b) preserve, maintain, and protect all State data until the earlier of a direction by the State to delete such data or the expiration of 90 days ("the retention period") from the date of termination or expiration of the Contract term; (c) after the retention period, the Contractor will securely dispose of and permanently delete all State data in all of its forms, such as disk, CD/DVD, backup tape and paper such that it is not recoverable, according to National Institute of Standards and Technology (NIST)-approved methods with certificates of destruction to be provided to the State; and (d) prepare an accurate accounting from which the State may reconcile all outstanding accounts. The final monthly invoice for the services provided hereunder will include all charges for the 90-day data retention period.

B. During any period of service suspension, the Contractor will maintain all State data in its then existing form, unless otherwise directed in writing by the Contract Monitor.

C. In addition to the foregoing, the State will be entitled to any post-termination/expiration assistance generally made available by Contractor with respect to the services.

3.3 Invoicing

3.3.1 General

A. The Contractor will e-mail the original of each invoice and signed authorization to invoice to the Contract Monitor and the EQRO Lead at e-mail address: mdh.hcqa@maryland.gov.

B. All invoices for services will be verified by the Contractor as accurate at the time of submission.

C. An invoice not satisfying the requirements of a Proper Invoice (as defined at COMAR 21.06.09.01 and .02) cannot be processed for payment. To be considered a Proper Invoice, invoices must include the following information, without error:

1. Contractor name and address;
2. Remittance address;
3. Federal taxpayer identification (FEIN) number, social security number, as appropriate;
4. Invoice period (i.e. time period during which services covered by invoice were performed);
5. Invoice date;
6. Invoice number;
7. State assigned Contract number;
8. State assigned (Blanket) Purchase Order number(s);
9. Goods or services provided;
10. Amount due; and
11. Any additional documentation required by regulation or the Contract.

D. Invoices that contain both fixed price and time and material items will clearly identify each item as either fixed price or time and material billing.

E. The Department reserves the right to reduce or withhold Contract payment in the event the Contractor does not provide the Department with all required deliverables within the time frame specified in the Contract or otherwise breaches the terms and conditions of the Contract until such time as the Contractor brings itself into full compliance with the Contract.

F. Any action on the part of the Department, or dispute of action by the Contractor, will be in accordance with the provisions of Md. Code Ann., State Finance and Procurement Article §§ 15-215 through 15-223 and with COMAR 21.10.04.

G. The State is generally exempt from federal excise taxes, Maryland sales and use taxes, District of Columbia sales taxes and transportation taxes. The Contractor; however, is not exempt from such sales and use taxes and may be liable for the same.

H. Invoices for final payment will be clearly marked as "FINAL" and submitted when all work requirements have been completed and no further charges are to be incurred under the Contract. In no event will any invoice be submitted later than 60 calendar days from the Contract termination date.

3.3.2 Invoice Submission Schedule

The Contractor will submit invoices in accordance with the following schedule:

A. For items of work for which there is one-time pricing (see **Attachment B** – Financial Proposal Form) those items will be billed in the month following the acceptance of the work by the Department.

B. For items of work for which there is annual pricing, see **Attachment B**– Financial Proposal Form, those items will be billed in equal monthly installments for the applicable Contract year in the month following the performance of the services.

3.3.3 For the purposes of the Contract an amount will not be deemed due and payable if:

A. The amount invoiced is inconsistent with the Contract;

B. The proper invoice has not been received by the party or office specified in the Contract;

C. The invoice or performance is in dispute or the Contractor has failed to otherwise comply with the provisions of the Contract;

D. The item or services have not been accepted;

E. The quantity of items delivered is less than the quantity ordered;

F. The items or services do not meet the quality requirements of the Contract;

G. If the Contract provides for progress payments, the proper invoice for the progress payment has not been submitted pursuant to the schedule;

H. If the Contract provides for withholding a retainage and the invoice is for the retainage, all stipulated conditions for release of the retainage have not been met; or

I. The Contractor has not submitted satisfactory documentation or other evidence reasonably required by the Procurement Officer or by the Contract concerning performance under the Contract and compliance with its provisions.

3.3.4 Travel Reimbursement

Travel will not be reimbursed under this RFP.

3.4 Liquidated Damages

3.4.1 MBE Liquidated Damages

MBE liquidated damages are identified in Attachment M.

3.4.2 Liquidated Damages other than MBE

THIS SECTION IS INAPPLICABLE TO THIS RFP.

3.5 Disaster Recovery and Data

The following requirements apply to the Contract:

3.5.1 Redundancy, Data Backup and Disaster Recovery

A. Unless specified otherwise in the RFP, Contractor will maintain or cause to be maintained disaster avoidance procedures designed to safeguard State data and other confidential information, Contractor's processing capability and the availability of hosted services, in each case throughout the Contract term. Any force majeure provisions of the Contract do not limit the Contractor's obligations under this provision.

B. The Contractor will have robust contingency and disaster recovery (DR) plans in place to ensure that the services provided under the Contract will be maintained in the event of disruption to the Contractor/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.

1. The Contractor will furnish a DR site.
2. The DR site will be at least 100 miles from the primary operations site, and have the capacity to take over complete production volume in case the primary site becomes unresponsive.

C. The contingency and DR plans must be designed to ensure that services under the Contract are restored after a disruption within twenty-four (24) hours from notification and a recovery point objective of one (1) hour or less prior to the outage in order to avoid unacceptable consequences due to the unavailability of services.

D. The Contractor will test the contingency/DR plans at least twice annually to identify any changes that need to be made to the plan(s) to ensure a minimum interruption of service. Coordination will be made with the State to ensure limited system downtime when testing is conducted. At least one (1) annual test will include backup media restoration and failover/fallback operations at the DR location. The Contractor will send the Contract Monitor a notice of completion following completion of DR testing.

E. Such contingency and DR plans will be available for the Department to inspect and practically test at any reasonable time, and subject to regular updating, revising, and testing throughout the term of the Contract.

3.5.2 Data Export/Import

A. The Contractor will, at no additional cost or charge to the State, in an industry standard/non-proprietary format:

1. perform a full or partial import/export of State data within 24 hours of a request; or
2. provide to the State the ability to import/export data at will and provide the State with any access and instructions which are needed for the State to import or export data.

B. Any import or export will be in a secure format per the Security Requirements.

3.5.3 Data Ownership and Access

A. Data, databases and derived data products created, collected, manipulated, or directly purchased as part of a RFP are the property of the State. The purchasing State agency is considered the custodian of the data and will determine the use, access, distribution and other conditions based on appropriate State statutes and regulations.

B. Public jurisdiction user accounts and public jurisdiction data will not be accessed, except (1) in the course of data center operations, (2) in response to service or technical issues, (3) as required by the express terms of the Contract, including as necessary to perform the services hereunder or (4) at the State's written request.

C. The Contractor will limit access to and possession of State data to only Contractor Personnel whose responsibilities reasonably require such access or possession and will train such Contractor Personnel on the confidentiality obligations set forth herein.

D. At no time will any data or processes – that either belong to or are intended for the use of the State or its officers, agents or employees – be copied, disclosed or retained by the Contractor or any party related to the Contractor for subsequent use in any transaction that does not include the State.

E. The Contractor will not use any information collected in connection with the services furnished under the Contract for any purpose other than fulfilling such services.

Provisions in Sections 3.5.1 – 3.5.3 will survive expiration or termination of the Contract. Additionally, the Contractor will flow down the provisions of Sections 3.5.1-3.5.3 (or the substance thereof) in all subcontracts.

3.6 Insurance Requirements

The Contractor will maintain, at a minimum, the insurance coverages outlined below, or any minimum requirements established by law if higher, for the duration of the Contract, including option periods, if exercised:

3.6.1 The following type(s) of insurance and minimum amount(s) of coverage are required:

A. Commercial General Liability - of $1,000,000 combined single limit per occurrence for bodily injury, property damage, and personal and advertising injury and $3,000,000 annual aggregate. The minimum limits required herein may be satisfied through any combination of primary and umbrella/excess liability policies.

B. Errors and Omissions/Professional Liability - $1,000,000 per combined single limit per claim and $3,000,000 annual aggregate.

C. Crime Insurance/Employee Theft Insurance - to cover employee theft with a minimum single loss limit of $1,000,000 per loss, and a minimum single loss retention not to exceed $10,000. The State of Maryland and the Department should be added as a "loss payee."

D. Cyber Security / Data Breach Insurance – (For any service offering hosted by the Contractor) ten million dollars ($10,000,000) per occurrence. The coverage must be valid at all locations where work is performed or data or other information concerning the State's claimants or employers is processed or stored.

E. Worker's Compensation - The Contractor will maintain such insurance as necessary or as required under Workers' Compensation Acts, the Longshore and Harbor Workers' Compensation Act, and the Federal Employers' Liability Act, to not be less than. one million dollars ($1,000,000) per occurrence (unless a state's law requires a greater amount of coverage). Coverage must be valid in all states where work is performed.

F. Automobile or Commercial Truck Insurance - The Contractor will maintain Automobile or Commercial Truck Insurance (including owned, leased, hired, and non-owned vehicles) as appropriate with Liability, Collision, and PIP limits no less than those required by the State where the vehicle(s) is registered, but in no case less than those required by the State of Maryland.

3.6.2 The State will be listed as an additional insured on the faces of the certificates associated with the coverages listed above, including umbrella policies, excluding Workers' Compensation Insurance and professional liability.

3.6.3 All insurance policies will be endorsed to include a clause requiring the insurance carrier provide the Procurement Officer, by certified mail, not less than 30 days' advance notice of any non-renewal, cancellation, or expiration. The Contractor will notify the Procurement Officer in writing, if policies are cancelled or not renewed within five (5) days of learning of such cancellation or nonrenewal. The Contractor will provide evidence of replacement insurance coverage to the Procurement Officer at least 15 days prior to the expiration of the insurance policy then in effect.

3.6.4 Any insurance furnished as a condition of the Contract will be issued by a company authorized to do business in the State.

3.6.5 The recommended awardee must provide current certificate(s) of insurance with the prescribed coverages, limits and requirements set forth in this section within five (5) Business Days from notice of recommended award. During the period of performance for multi-year contracts, the Contractor will provide certificates of insurance annually, or as otherwise directed by the Contract Monitor.

3.6.6 Subcontractor Insurance

The Contractor will require any subcontractors to obtain and maintain comparable levels of coverage and will provide the Contract Monitor with the same documentation as is required of the Contractor.

3.7 Security Requirements

The following requirements are applicable to the Contract:

3.7.1 Employee Identification

A. Contractor Personnel will display his or her company ID badge in a visible location at all times while on State premises. Upon request of authorized State personnel, each Contractor Personnel will provide additional photo identification.

B. Contractor Personnel will cooperate with State site requirements, including but not limited to, being prepared to be escorted at all times, and providing information for State badge issuance.

C. Contractor will remove any Contractor Personnel from working on the Contract where the State determines, in its sole discretion, that Contractor Personnel has not adhered to the Security requirements specified herein.

D. The State reserves the right to request that the Contractor submit proof of employment authorization of non-United States Citizens, prior to commencement of work under the Contract.

3.7.2 Security Clearance / Criminal Background Check

A. A criminal background check for each Contractor Personnel will be completed prior to each Contractor Personnel providing any services under the Contract.

B. The Contractor will obtain at its own expense a Criminal Justice Information System (CJIS) State and federal criminal background check, including fingerprinting, for all Contractor Personnel listed in sub-paragraph A. This check may be performed by a public or private entity.

C. Persons with a criminal record may not perform services under the Contract unless prior written approval is obtained from the Contract Monitor. The Contract Monitor reserves the right to reject any individual based upon the results of the background check. Decisions of the Contract Monitor as to acceptability of a candidate are final. The State reserves the right to refuse any individual Contractor Personnel to work on State premises, based upon certain specified criminal convictions, as specified by the State.

D. The CJIS criminal record check of each Contractor Personnel who will work on State premises will be reviewed by the Contractor for convictions of any of the following crimes described in the Annotated Code of Maryland, Criminal Law Article:

1. §§ 6-101 through 6-104, 6-201 through 6-205, 6-409 (various crimes against property);
2. any crime within Title 7, Subtitle 1 (various crimes involving theft);
3. §§ 7-301 through 7-303, 7-313 through 7-317 (various crimes involving telecommunications and electronics);
4. §§ 8-201 through 8-302, 8-501 through 8-523 (various crimes involving fraud);
5. §§9-101 through 9-417, 9-601 through 9-604, 9-701 through 9-706.1 (various crimes against public administration); or

6. a crime of violence as defined in CL § 14-101(a).

E. Contractor Personnel with access to systems supporting the State or to State data who have been convicted of a felony or of a crime involving telecommunications and electronics from the above list of crimes will not be permitted to work on State premises under the Contract; Contractor Personnel who have been convicted within the past five (5) years of a misdemeanor from the above list of crimes will not be permitted to work on State premises.

3.7.3 On-Site Security Requirement(s)

THIS SECTION IS INAPPLICABLE TO THIS RFP.

3.7.4 Information Technology

A. Contractors will comply with and adhere to the State IT Security Policy and Standards. These policies may be revised from time to time and the Contractor will comply with all such revisions. Updated and revised versions of the State IT Policy and Standards are available online at: www.doit.maryland.gov – keyword: Security Policy.

B. The Contractor will not connect any of its own equipment to a State LAN/WAN without prior written approval by the State. The Contractor will complete any necessary paperwork as directed and coordinated with the Contract Monitor to obtain approval by the State to connect Contractor-owned equipment to a State LAN/WAN.

The Contractor will:

1. Implement administrative, physical, and technical safeguards to protect State data that are no less rigorous than accepted industry best practices for information security such as those listed below (see **Section 3.7.5**);
2. Ensure that all such safeguards, including the manner in which State data is collected, accessed, used, stored, processed, disposed of and disclosed, comply with applicable data protection and privacy laws as well as the terms and conditions of the Contract; and
3. The Contractor, and Contractor Personnel, will (i) abide by all applicable federal, State and local laws, rules and regulations concerning security of Information Systems and Information Technology and (ii) comply with and adhere to the State IT Security Policy and Standards as each may be amended or revised from time to time. Updated and revised versions of the State IT Policy and Standards are available online at: www.doit.maryland.gov – keyword: Security Policy.

3.7.5 Data Protection and Controls

A. Contractor will ensure a secure environment for all State data and any hardware and software (including but not limited to servers, network and data components) provided or used in connection with the performance of the Contract and will apply or cause application of appropriate controls so as to maintain such a secure environment ("Security Best Practices"). Such Security Best Practices will comply with an accepted industry standard, such as the NIST cybersecurity framework.

B. To ensure appropriate data protection safeguards are in place, the Contractor will implement and maintain the following controls at all times throughout the Term of the Contract (the Contractor may augment this list with additional controls):

1) Establish separate production, test, and training environments for systems supporting the services provided under the Contract and ensure that production data is not replicated in test or training environment(s) unless it has been previously anonymized or otherwise modified to protect the confidentiality of Sensitive Data elements. The Contractor will ensure the appropriate separation of production and non-production environments by applying the data protection and control requirements listed in **Section 3.7.5**.

2) Apply hardware and software hardening procedures as recommended by Center for Internet Security (CIS) guides https://www.cisecurity.org/, Security Technical Implementation Guides (STIG) http://iase.disa.mil/Pages/index.aspx, or similar industry best practices to reduce the systems' surface of vulnerability, eliminating as many security risks as possible and documenting what is not feasible or not performed according to best practices. Any hardening practices not implemented will be documented with a plan of action and milestones including any compensating control. These procedures may include but are not limited to removal of unnecessary software, disabling or removing unnecessary services, removal of unnecessary usernames or logins, and the deactivation of unneeded features in the Contractor's system configuration files.

3) Ensure that State data is not comingled with non-State data through the proper application of compartmentalization Security Measures.

4) Apply data encryption to protect Sensitive Data at all times, including in transit, at rest, and also when archived for backup purposes. Unless otherwise directed, the Contractor is responsible for the encryption of all Sensitive Data.

5) For all State data the Contractor manages or controls, data encryption will be applied to such data in transit over untrusted networks.

6) Encryption algorithms which are utilized for encrypting data will comply with current Federal Information Processing Standards (FIPS), "Security Requirements for Cryptographic Modules", FIPS PUB 140-2:

   http://csrc.nist.gov/publications/fips/fips140-2/fips1402.pdf

   http://csrc.nist.gov/groups/STM/cmvp/documents/140-1/1401vend.htm

7) Enable appropriate logging parameters to monitor user access activities, authorized and failed access attempts, system exceptions, and critical information security events as recommended by the operating system and application manufacturers and information security standards, including Maryland Department of Information Technology's Information Security Policy.

8) Retain the aforementioned logs and review them at least daily to identify suspicious or questionable activity for investigation and documentation as to their cause and remediation, if required. The Department will have the right to inspect these policies and procedures and the Contractor or subcontractor's performance to confirm the effectiveness of these measures for the services being provided under the Contract.

9) Ensure system and network environments are separated by properly configured and updated firewalls.

10) Restrict network connections between trusted and untrusted networks by physically or logically isolating systems from unsolicited and unauthenticated network traffic.

11) By default "deny all" and only allow access by exception.

12) Review, at least annually, the aforementioned network connections, documenting and confirming the business justification for the use of all service, protocols, and ports allowed, including the rationale or compensating controls implemented for those protocols considered insecure but necessary.

13) Perform regular vulnerability testing of operating system, application, and network devices. Such testing is expected to identify outdated software versions; missing software patches; device or software misconfigurations; and to validate compliance with or deviations from the security policies applicable to the Contract. Contractor will evaluate all identified vulnerabilities for potential adverse effect on security and integrity and remediate the vulnerability no later than 30 days following the earlier of vulnerability's identification or public disclosure, or document why remediation action is unnecessary or unsuitable. The Department will have the right to inspect the Contractor's policies and procedures and the results of vulnerability testing to confirm the effectiveness of these measures for the services being provided under the Contract.

14) Enforce strong user authentication and password control measures to minimize the opportunity for unauthorized access through compromise of the user access controls. At a minimum, the implemented measures should be consistent with the most current Maryland Department of Information Technology's Information Security Policy (http://doit.maryland.gov/support/Pages/SecurityPolicies.aspx), including specific requirements for password length, complexity, history, and account lockout.

15) Ensure State data is not processed, transferred, or stored outside of the United States ("U.S."). The Contractor will provide its services to the State and the State's end users solely from data centers in the U.S. Unless granted an exception in writing by the State, the Contractor will not allow Contractor Personnel to store State data on portable devices, including personal computers, except for devices that are used and kept only at its U.S. data centers. The Contractor will permit its Contractor Personnel to access State data remotely only as required to provide technical support.

16) Ensure Contractor's Personnel will not connect any of its own equipment to a State LAN/WAN without prior written approval by the State, which may be revoked at any time for any reason. The Contractor will complete any necessary paperwork as directed and coordinated with the Contract Monitor to obtain approval by the State to connect Contractor -owned equipment to a State LAN/WAN.

17) Ensure that anti-virus and anti-malware software is installed and maintained on all systems supporting the services provided under the Contract; that the anti-virus and anti-malware software is automatically updated; and that the software is configured to actively scan and detect threats to the system for remediation. The Contractor will perform routine vulnerability scans and take corrective actions for any findings.

18) Conduct regular external vulnerability testing designed to examine the service provider's security profile from the Internet without benefit of access to internal systems and networks behind the external security perimeter. Evaluate all identified vulnerabilities on Internet-facing devices for potential adverse effect on the service's security and integrity and remediate the vulnerability promptly or document why remediation action is unnecessary or unsuitable. The Department

will have the right to inspect these policies and procedures and the performance of vulnerability testing to confirm the effectiveness of these measures for the services being provided under the Contract.

3.7.6 Security Plan

A. The Contractor will protect State data according to a written security policy ("Security Plan") no less rigorous than that of the State, and will supply a copy of such policy to the State for validation, with any appropriate updates, on an annual basis.

B. The Security Plan will detail the steps and processes employed by the Contractor as well as the features and characteristics which will ensure compliance with the security requirements of the Contract.

C. The Security Plan will address compliance with the PCI DSS for payment card processing).

3.7.7 Security Incident Response

A. The Contractor will notify the Department in accordance with **Section 3.7.9A-D** when any Contractor system that may access, process, or store State data or State systems experiences a Security Incident or a Data Breach as follows:

1) notify the Department within twenty-four (24) hours of the discovery of a Security Incident by providing notice via written or electronic correspondence to the Contract Monitor, Department chief information officer and Department chief information security officer;

2) notify the Department within two (2) hours if there is a threat to Contractor's Solution as it pertains to the use, disclosure, and security of State data; and

3) provide written notice to the Department within one (1) Business Day after Contractor's discovery of unauthorized use or disclosure of State data and thereafter all information the State (or Department) requests concerning such unauthorized use or disclosure.

B. Contractor's notice will identify:

1) the nature of the unauthorized use or disclosure;

2) the State data used or disclosed,

3) who made the unauthorized use or received the unauthorized disclosure;

4) what the Contractor has done or will do to mitigate any deleterious effect of the unauthorized use or disclosure; and

5) what corrective action the Contractor has taken or will take to prevent future similar unauthorized use or disclosure.

6) The Contractor will provide such other information, including a written report, as reasonably requested by the State.

C. The Contractor may need to communicate with outside parties regarding a Security Incident, which may include contacting law enforcement, fielding media inquiries and seeking external expertise as mutually agreed upon, defined by law or contained in the Contract. Discussing Security Incidents with the State should be handled on an urgent as-needed basis, as part of

Contractor communication and mitigation processes as mutually agreed upon, defined by law or contained in the Contract.

D. The Contractor will comply with all applicable laws that require the notification of individuals in the event of unauthorized release of State data or other event requiring notification, and, where notification is required, assume responsibility for informing all such individuals in accordance with applicable law and to indemnify and hold harmless the State (or Department) and its officials and employees from and against any claims, damages, and actions related to the event requiring notification.

3.7.8 Data Breach Responsibilities

A. If the Contractor reasonably believes or has actual knowledge of a Data Breach, the Contractor will, unless otherwise directed:

1) Notify the appropriate State-identified contact within 24 hours by telephone in accordance with the agreed upon security plan or security procedures unless a shorter time is required by applicable law;

2) Cooperate with the State to investigate and resolve the data breach;

3) Promptly implement commercially reasonable remedial measures to remedy the Data Breach; and

4) Document responsive actions taken related to the Data Breach, including any post-incident review of events and actions taken to make changes in business practices in providing the services.

B. If a Data Breach is a direct result of the Contractor's breach of its Contract obligation to encrypt State data or otherwise prevent its release, the Contractor will bear the costs associated with (1) the investigation and resolution of the data breach; (2) notifications to individuals, regulators or others required by State law; (3) a credit monitoring service required by State or federal law; (4) a website or a toll-free number and call center for affected individuals required by State law; and (5) complete all corrective actions as reasonably determined by Contractor based on root cause; all [(1) through (5)] subject to the Contract's limitation of liability.

3.7.9 The State will, at its discretion, have the right to review and assess the Contractor's compliance to the security requirements and standards defined in the Contract.

3.7.10 Provisions in **Sections 3.7.1 – 3.7.10** will survive expiration or termination of the Contract. Additionally, the Contractor will flow down the provisions of **Sections 3.7.4-3.7.10** (or the substance thereof) in all subcontracts.

3.8 Problem Escalation Procedure

3.8.1 The Contractor must provide and maintain a Problem Escalation Procedure (PEP) for both routine and emergency situations. The PEP must state how the Contractor will address problem situations as they occur during the performance of the Contract, especially problems that are not resolved to the satisfaction of the State within appropriate timeframes.

3.8.2 The Contractor will provide contact information to the Contract Monitor, as well as to other State personnel as directed should the Contract Monitor not be available.

3.8.3 The Contractor must provide the PEP no later than ten (10) Business Days after notice of recommended award. The PEP, including any revisions thereto, must also be provided within ten (10) Business Days after the start of each Contract year and within ten (10) Business Days after any change in circumstance which changes the PEP. The PEP will detail how problems with work under the Contract will be escalated in order to resolve any issues in a timely manner. The PEP will include:

A. The process for establishing the existence of a problem;

B. Names, titles, and contact information for progressively higher levels of personnel in the Contractor's organization who would become involved in resolving a problem;

C. For each individual listed in the Contractor's PEP, the maximum amount of time a problem will remain unresolved with that individual before the problem escalates to the next contact person listed in the Contractor's PEP;

D. Expedited escalation procedures and any circumstances that would trigger expediting them;

E. The method of providing feedback on resolution progress, including the frequency of feedback to be provided to the State;

F. Contact information for persons responsible for resolving issues after normal business hours (e.g., evenings, weekends, holidays) and on an emergency basis; and

G. A process for updating and notifying the Contract Monitor of any changes to the PEP.

3.8.4 Nothing in this section will be construed to limit any rights of the Contract Monitor or the State which may be allowed by the Contract or applicable law.

3.9 SOC 2 Type 2 Audit Report

3.9.1 A SOC 2 Type 2 Audit applies to the Contract. The applicable trust principles are: Security and Confidentiality as defined in the aforementioned Guidance.

3.9.2 In the event the Contractor provides services for identified critical functions, handles Sensitive Data, or hosts any related implemented system for the State under the Contract, the Contractor will have an annual audit performed by an independent audit firm of the Contractor's handling of Sensitive Data or the Department's critical functions. Critical functions are identified as all aspects and functionality of the Solution including any add-on modules and will address all areas relating to Information Technology security and operational processes. These services provided by the Contractor that will be covered by the audit will collectively be referred to as the "Information Functions and Processes." Such audits will be performed in accordance with audit guidance: Reporting on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy (SOC 2) as published by the American Institute of Certified Public Accountants (AICPA) and as updated from time to time, or according to the most current audit guidance promulgated by the AICPA or similarly-recognized professional

organization, as agreed to by the Department, to assess the security of outsourced client functions or data (collectively, the "Guidance") as follows:

A. The type of audit to be performed in accordance with the Guidance is a SOC 2 Type 2 Audit (referred to as the "SOC 2 Audit" or "SOC 2 Report"). All SOC2 Audit Reports will be submitted to the Contract Monitor as specified in Section F below. The initial SOC 2 Audit will be completed within a timeframe to be specified by the State. The audit period covered by the initial SOC 2 Audit will start with the Contract Effective Date unless otherwise agreed to in writing by the Contract Monitor. All subsequent SOC 2 Audits after this initial audit will be performed at a minimum on an annual basis throughout the Term of the Contract, and will cover a 12-month audit period or such portion of the year that the Contractor furnished services.

B. The SOC 2 Audit will report on the suitability of the design and operating effectiveness of controls over the Information Functions and Processes to meet the requirements of the Contract, including the Security Requirements identified in **Section 3.7**, relevant to the trust principles identified in 3.9.1: as defined in the aforementioned Guidance.

C. The audit scope of each year's SOC 2 Report may need to be adjusted (including the inclusion or omission of the relevant trust services principles of Security, Availability, Processing Integrity, Confidentiality, and Privacy) to accommodate any changes to the environment since the last SOC 2 Report. Such changes may include but are not limited to the addition of Information Functions and Processes through modifications to the Contract or due to changes in Information Technology or the operational infrastructure. The Contractor will ensure that the audit scope of each year's SOC 2 Report engagement will accommodate these changes by including in the SOC 2 Report all appropriate controls related to the current environment supporting the Information Functions and/or Processes, including those controls required by the Contract.

D. The scope of the SOC 2 Report will include work performed by any subcontractors that provide essential support to the TO Contractor or essential support to the Information Functions and Processes provided to the Department under the Contract. The Contractor will ensure the audit includes all such subcontractors operating in performance of the Contract.

E. All SOC 2 Audits, including those of the Contractor, will be performed at no additional expense to the Department.

F. The Contractor will provide to the Contract Monitor, within 30 calendar days of the issuance of each SOC 2 Report, a complete copy of the final SOC 2 Report(s) and a documented corrective action plan addressing each audit finding or exception contained in the SOC 2 Report. The corrective action plan will identify in detail the remedial action to be taken by the Contractor along with the date(s) when each remedial action is to be implemented.

G. If the Contractor currently has an annual, independent information security assessment performed that includes the operations, systems, and repositories of the Information Functions and Processes being provided to the Department under the Contract, and if that assessment generally conforms to the content and objective of the Guidance, the Department will determine in consultation with appropriate State

government technology and audit authorities whether the Contractor's current information security assessments are acceptable in lieu of the SOC 2 Report(s).

H. If the Contractor fails during the Contract term to obtain an annual SOC 2 Report by the date specified in **Section 3.9.2.A**, the Department will have the right to retain an independent audit firm to perform an audit engagement of a SOC 2 Report of the Information Functions and Processes utilized or provided by the Contractor and under the Contract. The Contractor agrees to allow the independent audit firm to access its facility/ies for purposes of conducting this audit engagement(s), and will provide the necessary support and cooperation to the independent audit firm that is required to perform the audit engagement of the SOC 2 Report. The Department will invoice the Contractor for the expense of the SOC 2 Report(s), or deduct the cost from future payments to the Contractor.

I. Provisions in **Section 3.9.1-2** will survive expiration or termination of the Contract. Additionally, the Contractor and will flow down the provisions of **Section 3.9.1-2** (or the substance thereof) in all subcontracts.

3.10 Experience and Personnel

3.10.1 Preferred Offeror Experience

The following experience is expected and will be evaluated as part of the Technical Proposal (see the Offeror experience, capability and references evaluation factor from **Section 6.2**):

A. Demonstrate the ability to build strong professional relationships with MCOs. Demonstrate previous experience in learning program requirements and how it is integrated in the quality review process.

B. Prior senior level experience working with a state that has multiple MCOs, validating network adequacy for large Medicaid managed care organizations, and providing technical assistance to MCOs and states on quality related matters.

C. Breadth of knowledge in conducting external review for large Medicaid Programs and federal requirements for external quality review.

D. Familiarity with quality of care standards and managed care organizational structure.

3.10.2 Personnel Experience

The following experience is expected and will be evaluated as part of the Technical Proposal (see the capability of proposed resources evaluation factor from **Section 6.2**):

A. Demonstrated knowledge of auditing practices and principals.

B. Prior senior level experience working with a state that has multiple MCOs, validating network adequacy for large Medicaid managed care organizations, and providing technical assistance to MCOs and states on quality related matters.

C. Breadth of knowledge in conducting external review for large Medicaid Programs and federal requirements for external quality review

D. Familiarity with auditing practices and principals, independent review requirements for external quality review process, and NCQA accreditation and standards and federal regulations. Familiarity with Medicaid and Managed Care organizations.

3.10.3 Number of Personnel to Propose

As part of the Proposal evaluation, Offerors will propose a number of personnel who are expected to be available as of the start date specified in the Notice to Proceed (NTP Date). Offerors will describe in a Staffing Plan how additional resources will be acquired to meet the needs of the Department. Offerors may generally describe planned positions in a Staffing Plan. Such planned positions may not be used as evidence of fulfilling personnel minimum qualifications.

3.10.4 Key Personnel Identified

The Contractor shall identify all Key Personnel (see Appendix 1) and support personnel necessary for completing the requirements of this RFP. All staff identified as Key Personnel shall be subject to the requirements in Section 3.11. At a minimum, the Contractor shall identify a Quality Improvement Director who will be Key Personnel and who will serve as the main point of contact for the CM. The Quality Improvement Director is responsible for all communications related to the activities identified in this Scope of Work.

A. Quality Improvement Director

    1. Experienced Project Manager with knowledge of Medicaid Managed Care Organization and external quality review activities. The Director will provide strategic planning and serve as a liaison between the Managed Care Organizations (MCOs) and the Department to administer contract activities.

3.10.5 Contractor Personnel Maintain Certifications

Any Contractor Personnel provided under this RFP will maintain in good standing any required professional certifications for the duration of the Contract.

3.10.6 Work Hours

Unless otherwise specified, the following work hours requirements are applicable:

A. Business Hours Support: Contractor will assign Contractor Personnel to support Normal State Business Hours (see Appendix 1).

B. Contractor Personnel may also be required to provide occasional support outside of normal State Business Hours, including evenings, overnight, and weekends, to support specific efforts and emergencies, such as to resolve system repair or restoration. Hours performing activities must be billed on an actual time worked basis at the rates proposed.

C. State-Mandated Closings: Contractor Personnel will be required to participate in any State-mandated closings. In this event, the Contractor will be notified in writing by the Contract Monitor of these details.

D. Minimum and Maximum Hours: Full-time Contractor Personnel will work 40 hours per week with starting and ending times as approved by the Contract Monitor. A flexible work schedule may be used with Contract Monitor approval, including time to support any efforts outside core business hours. Contractor personnel may also be requested to restrict the number of hours Contractor personnel can work within a given period of time that may result in less than an eight-hour day or less than a 40-hour work week.

E. Vacation Hours: Requests for leave will be submitted to the Contract Monitor at least two weeks in advance. The Contract Monitor reserves the right to request a

temporary replacement if leave extends longer than one consecutive week. In cases where there is insufficient coverage, a leave request may be denied.

3.11 Substitution of Personnel

3.11.1 Continuous Performance of Key Personnel

When Key Personnel are identified for the Contract, the following apply:

A. Key Personnel will be available to perform Contract requirements as of the NTP Date. Unless explicitly authorized by the Contract Monitor or specified in the Contract, Key Personnel will be assigned to the State of Maryland as a dedicated resource.

B. Key Personnel will perform continuously for the duration of the Contract, or such lesser duration as specified in the Technical Proposal. Key Personnel may not be removed by the Contractor from working under the Contract without the prior written approval of the Contract Monitor.

C. The provisions of this section apply to Key Personnel identified in any Task Order proposal and agreement, if issued, and any Work Order Request and Work Order, if issued.

3.11.2 Definitions

For the purposes of this section, the following definitions apply:

A. **Extraordinary Personal Event** – means any of: leave under the Family Medical Leave Act; an Incapacitating injury or Incapacitating illness; or other circumstances that in the sole discretion of the State warrant an extended leave of absence, such as extended jury duty or extended military service that precludes the individual from performing his/her job duties under the Contract.

B. **Incapacitating** – means any health circumstance that substantially impairs the ability of an individual to perform the job duties described for that individual's position in the RFP or the Contractor's Technical Proposal.

3.11.3 Contractor Personnel General Substitution Provisions

The following provisions apply to all of the circumstances of Contractor Personnel substitution described in **Section 3.11.4**.

A. The Contractor will demonstrate to the Contract Monitor's satisfaction that the proposed substitute has qualifications at least equal to those of the Contractor Personnel proposed to be replaced.

B. The Contractor will provide the Contract Monitor with a substitution request that will include:

1) A detailed explanation of the reason(s) for the substitution request;

2) The resume of the proposed substitute, signed by the substituting individual and his/her formal supervisor;

3) The official resume of the current personnel for comparison purposes; and

4) Evidence of any required credentials.

C. The Contract Monitor may request additional information concerning the proposed substitution and may interview the proposed substitute personnel prior to deciding whether to approve the substitution request.

D. The Contract Monitor will notify the Contractor in writing of: (i) the acceptance or denial, or (ii) contingent or temporary approval for a specified time limit, of the requested substitution. The Contract Monitor will not unreasonably withhold approval of a proposed Contractor Personnel replacement.

3.11.4 Replacement Circumstances

A. Directed Personnel Replacement

1) The Contract Monitor may direct the Contractor to replace any Contractor Personnel who, in the sole discretion of the Contract Monitor, are perceived as being unqualified, non-productive, unable to fully perform the job duties, disruptive, or known, or reasonably believed, to have committed a major infraction(s) of law, Department policies, or Contract requirements. Normally, a directed personnel replacement will occur only after prior notification of problems with requested remediation, as described in paragraph **3.11.4.A.2**.

2) If deemed appropriate in the discretion of the Contract Monitor, the Contract Monitor may give written notice of any Contractor Personnel performance issues to the Contractor, describing the problem and delineating the remediation requirement(s). The Contractor will provide a written response to the remediation requirements in a Remediation Plan within ten (10) days of the date of the notice and will immediately implement the Remediation Plan upon written acceptance by the Contract Monitor. If the Contract Monitor rejects the Remediation Plan, the Contractor will revise and resubmit the plan to the Contract Monitor within five (5) days, or in the timeframe set forth by the Contract Monitor in writing.

3) Should performance issues persist despite an approved Remediation Plan, the Contract Monitor may give written notice of the continuing performance issues and either request a new Remediation Plan within a specified time limit or direct the substitution of Contractor Personnel whose performance is at issue with a qualified substitute, including requiring the immediate removal of the Contractor Personnel at issue.

4) Replacement or substitution of Contractor Personnel under this section will be in addition to, and not in lieu of, the State's remedies under the Contract or which otherwise may be available at law or in equity.

5) If the Contract Monitor determines to direct substitution under **3.11.4.A.1**, if at all possible, at least fifteen (15) days advance notice will be given to the Contractor. However, if the Contract Monitor deems it necessary and in the State's best interests to remove the Contractor Personnel with less than fifteen (15) days' notice, the Contract Monitor may direct the removal in a timeframe of less than fifteen (15) days, including immediate removal.

6) In circumstances of directed removal, the Contractor will, in accordance with paragraph **3.11.4.A.1** of this section, provide a suitable replacement for approval within fifteen (15) days of the notification of the need for removal, or the actual removal, whichever occurs first.

B. Key Personnel Replacement

1) To replace any Key Personnel in a circumstance other than as described in **3.11.4.B**, including transfers and promotions, the Contractor will submit a substitution request as described in **Section 3.11.3** to the Contract Monitor at least fifteen (15) days prior to the intended date of change. A substitution may not occur unless and until the Contract Monitor approves the substitution in writing.

2) Key Personnel Replacement Due to Sudden Vacancy

   a) The Contractor will replace Key Personnel whenever a sudden vacancy occurs (e.g., Extraordinary Personal Event, death, resignation, termination). A termination or resignation with thirty (30) days or more advance notice will be treated as a replacement under **Section 3.11.4.B.1**.

   b) Under any of the circumstances set forth in this paragraph B, the Contractor will identify a suitable replacement and provide the same information and items required under **Section 3.11.3** within fifteen (15) days of the actual vacancy occurrence or from when the Contractor first knew or should have known that the vacancy would be occurring, whichever is earlier.

3) Key Personnel Replacement Due to an Indeterminate Absence

   a) If any Key Personnel has been absent from his/her job for a period of ten (10) days and it is not known or reasonably anticipated that the individual will be returning to work within the next twenty (20) days to fully resume all job duties, before the 25th day of continuous absence, the Contractor will identify a suitable replacement and provide the same information and items to the Contract Monitor as required under **Section 3.11.3**.

   b) However, if this person is available to return to work and fully perform all job duties before a replacement has been authorized by the Contract Monitor the Contract Monitor may, at his/her sole discretion, authorize the original personnel to continue to work under the Contract, or authorize the replacement personnel to replace the original personnel, notwithstanding the original personnel's ability to return.

3.11.5 Substitution Prior to and Within 30 Days After Contract Execution

Prior to Contract execution or within thirty (30) days after Contract execution, the Offeror may not substitute proposed Key Personnel except under the following circumstances (a) for actual full-time personnel employed directly by the Offeror: the vacancy occurs due to the sudden termination, resignation, or approved leave of absence due to an Extraordinary Personal Event, or the death of such personnel; and (b) for any temporary staff, subcontractors or 1099 contractors: the vacancy occurs due to an Incapacitating event or the death of such personnel. To qualify for such substitution, the Offeror must demonstrate to the State's satisfaction the event necessitating substitution. Proposed substitutions will be of equal caliber or higher, in the State's sole discretion. Proposed substitutes deemed by the State to be less qualified than the originally proposed individual may be grounds for pre-award disqualification or post-award termination.

3.12 Minority Business Enterprise (MBE) Reports

If this solicitation includes an MBE Goal (see **Section 4.26**), the Contractor will:

A. Submit the following reports by the 10th of each month to the Contract Monitor and the Department's MBE Liaison Officer:

1. A Prime Contractor Paid/Unpaid MBE Invoice Report (**Attachment D-4A**) listing any unpaid invoices, over 45 days old, received from any certified MBE subcontractor, the amount of each invoice and the reason payment has not been made; and
2. (If Applicable) An MBE Prime Contractor Report (**Attachment D-4B**) identifying an MBE prime's self-performing work to be counted towards the MBE participation goals.

B. Include in its agreements with its certified MBE subcontractors a requirement that those subcontractors submit an MBE Subcontractor Paid/Unpaid Invoice Report (**Attachment D-5**) by the 10th of each month to the Contract Monitor and the Department's MBE Liaison Officer that identifies the Contract and lists all payments to the MBE subcontractor received from the Contractor in the preceding reporting period month, as well as any outstanding invoices, and the amounts of those invoices.

C. Maintain such records as are necessary to confirm compliance with its MBE participation obligations. These records must indicate the identity of certified minority and non-minority subcontractors employed on the Contract, type of work performed by each, and actual dollar value of work performed. Subcontract agreements documenting the work performed by all MBE participants must be retained by the Contractor and furnished to the Procurement Officer on request.

D. Consent to provide such documentation as reasonably requested and to provide right-of-entry at reasonable times for purposes of the State's representatives verifying compliance with the MBE participation obligations. Contractor must retain all records concerning MBE participation and make them available for State inspection for three years after final completion of the Contract.

E. Upon completion of the Contract and before final payment and release of retainage, submit a final report in affidavit form and under penalty of perjury, of all payments made to, or withheld from MBE subcontractors.

3.13 Veteran Small Business Enterprise (VSBE) Reports

If this solicitation includes a VSBE Goal (see **Section 4.27**), the Contractor will:

A. Submit the following reports by the 10th of the month following the reporting period to the Contract Monitor and the Department VSBE representative:

   a. VSBE Participation Prime Contractor Paid/Unpaid VSBE Invoice Report (**Attachment E-3**) listing any unpaid invoices, over 45 days old, received from any VSBE subcontractor, the amount of each invoice and the reason payment has not been made; and

   b. **Attachment E-4**, the VSBE Participation Subcontractor Paid/Unpaid VSBE Invoice Report by the 10th of the month following the reporting period to the Contract Monitor and the VSBE Liaison Officer.

B. Include in its agreements with its VSBE subcontractors a requirement that those subcontractors submit monthly by the 10th of the month following the reporting period to the Contract Monitor and Department VSBE representative a report that identifies the prime contract and lists all payments received from Contractor in the preceding reporting period month, as well as any outstanding invoices, and the amount of those invoices (**Attachment E-4**).

C. Maintain such records as are necessary to confirm compliance with its VSBE participation obligations. These records must indicate the identity of VSBE and non-VSBE subcontractors employed on the contract, the type of work performed by each, and the actual dollar value of work performed. The subcontract agreement documenting the work performed by all VSBE participants must be retained by the Contractor and furnished to the Procurement Officer on request.

D. Consent to provide such documentation as reasonably requested and to provide right-of-entry at reasonable times for purposes of the State's representatives verifying compliance with the VSBE participation obligations. The Contractor must retain all records concerning VSBE participation and make them available for State inspection for three years after final completion of the Contract.

E. At the option of the Department, upon completion of the Contract and before final payment and release of retainage, submit a final report in affidavit form and under penalty of perjury, of all payments made to, or withheld from VSBE subcontractors.

3.14 Work Orders

THIS SECTION IS INAPPLICABLE TO THIS RFP.

3.15 Additional Clauses

3.15.1 Purchasing and Recycling Electronic Products

This section does not apply to this solicitation.

3.15.2 Change Control and Advance Notice

A. Unless otherwise specified in an applicable Service Level Agreement, the Contractor will give seven (7) days advance notice to the State of any upgrades or modifications that may impact service availability and performance.

B. Contractor may not modify the functionality or features of any SaaS provided hereunder if such modification materially degrades the functionality of the SaaS.

3.15.3 No-Cost Extensions

In accordance with BPW Advisory 1995-1 item 7.b, in the event there are unspent funds remaining on the Contract, prior to the Contract's expiration date the Procurement Officer may modify the Contract to extend the Contract beyond its expiration date for a period up to, but not exceeding, one-third of the base term of the Contract (e.g., eight-month extension on a two-year contract) for the performance of work within the Contract's scope of work. Notwithstanding anything to the contrary, no funds may be added to the Contract in connection with any such extension.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

4 Procurement Instructions

4.1 Pre-Proposal Conference

Virtual Teleconference by Calendar Invitation from Procurement Officer Only

See **Attachment A** for instructions.

4.1.1 A virtual (audio only and/or web-based) Pre-Proposal conference (Conference) will be held at the date, time, and location indicated on the Key Information Summary Sheet. Remote participation in the Conference can occur either by calling into a pre-provided phone number or by pre-registering for web participation as describes below. The phone number and other audio participation information will be provided in the Key Information Summary Sheet, the Pre-Proposal Conference Response Form (Attachment A) or via eMMA (see **Section 4.2.1** eMMA).

4.1.2 Participation in the Conference is not mandatory, but all interested parties are encouraged to attend in order to facilitate better preparation of their Proposals. MBE subcontractors are encouraged to participate in the Conference to market their participation to potential prime contractors.

4.1.3 Following the Conference, the attendance record and summary of the Conference will be distributed via the same mechanism described for amendments and questions (see Section 4.2.1 eMMA).

4.1.4 Attendees should obtain a copy of the solicitation in order to adequately follow along during the conference.

4.1.5 Please e-mail the Pre-Proposal Response form (Attachment A) to the Procurement Coordinator at least two (2) Business Days prior to the pre-proposal conference. The Procurement Coordinator will provide additional information on how to attend the web conference to all that submit the Pre-Proposal Response form by the time noted above. In addition, if there is a need for sign language interpretation or other reasonable accommodations due to a disability, please notify the Procurement Coordinator.

4.2 eMaryland Marketplace Advantage (eMMA)

4.2.1 eMMA is the electronic commerce system for the State of Maryland. The RFP, Conference summary and attendance sheet, Offerors' questions and the Procurement Officer's responses, addenda, and other solicitation-related information will be made available via eMMA.

4.2.2 In order to receive a contract award, a vendor must be registered on eMMA. Registration is free. Go to, click on "Register" to begin the process, and then follow the prompts.

4.3 Questions

4.3.1 All questions, including concerns regarding any applicable MBE or VSBE participation goals, will identify in the subject line the Solicitation Number and Title (MDH OPASS #21-18957 - External Quality Review of the Maryland

HealthChoice Program), and will be submitted in writing via e-mail to the Procurement Officer at least five (5) days prior to the Proposal due date. The Procurement Officer, based on the availability of time to research and communicate an answer, will decide whether an answer can be given before the Proposal due date.

4.3.2 Answers to all questions that are not clearly specific only to the requestor will be distributed via the same mechanism as for RFP amendments, and posted on eMMA.

4.3.3 The statements and interpretations contained in responses to any questions, whether responded to verbally or in writing, are not binding on the Department unless it issues an amendment in writing.

4.4 Procurement Method

A Contract will be awarded in accordance with the Competitive Sealed Proposals method under COMAR 21.05.03.

4.5 Proposal Due (Closing) Date and Time

4.5.1 Proposals, in the number and form set forth in **Section 5 Proposal Format**, must be received by the Procurement Officer no later than the Proposal due date and time indicated on the Key Information Summary Sheet in order to be considered.

4.5.2 Requests for extension of this date or time will not be granted.

4.5.3 Offerors submitting Proposals should allow sufficient delivery time to ensure timely receipt by the Procurement Officer. Except as provided in COMAR 21.05.03.02.F and 21.05.02.10, Proposals received after the due date and time listed in the Key Information Summary Sheet will not be considered.

4.5.4 The date and time of an email submission is determined by the date and time of arrival in the e-mail address as indicated on the Key Information Summary Sheet.

4.5.5 Proposals may be modified or withdrawn by written notice received by the Procurement Officer before the time and date set forth in the Key Information Summary Sheet for receipt of Proposals.

4.5.6 Proposals will not be opened publicly.

4.5.7 Potential Offerors not responding to this solicitation are requested to submit the "Notice to Vendors" form, which includes company information and the reason for not responding (e.g., too busy, cannot meet mandatory requirements).

4.6 Multiple or Alternate Proposals

Multiple or alternate Proposals will not be accepted.

4.7 Economy of Preparation

Proposals should be prepared simply and economically and provide a straightforward and concise description of the Offeror's Proposal to meet the requirements of this RFP.

4.8 Public Information Act Notice

4.8.1 The Offeror should give specific attention to the clear identification of those portions of its Proposal that it considers confidential and/or proprietary commercial information or trade secrets, and provide justification why such materials, upon request, should not be disclosed by the State under the Public Information Act, Md. Code Ann., General Provisions Article, Title 4 (See also RFP **Section 5.3.2.B** "Claim of Confidentiality"). This information should be identified by page and section number and placed after the Title Page and before the Table of Contents in the Technical Proposal and if applicable, separately in the Financial Proposal.

4.8.2 Offerors are advised that, upon request for this information from a third party, the Procurement Officer is required to make an independent determination whether the information must be disclosed.

4.9 Award Basis

A Contract will be awarded to the responsible Offeror(s) submitting the Proposal that has been determined to be the most advantageous to the State, considering price and evaluation factors set forth in this RFP (see COMAR 21.05.03.03F), for providing the goods and services as specified in this RFP. See RFP **Section 6** for further award information.

4.10 Oral Presentation

Offerors may be required to make oral presentations to State representatives via Google Meet. Oral presentations are considered part of the Technical Proposal. Offerors must confirm in writing any substantive oral clarification of, or change in, their Proposals made in the course of discussions. Any such written clarifications or changes then become part of the Offeror's Proposal. The Procurement Officer will notify Offerors of the date and time of oral presentations via email and calendar invitation. The Procurement Officer will also provide Offerors with an opportunity to "test" the Google Meet environment by sending a one (1) hour "practice" calendar invite within two (2) Business Days of the Offerors oral presentation date.

4.11 Duration of Proposal

Proposals submitted in response to this RFP are irrevocable for the latest of the following: 120 days following the Proposal due date and time, best and final offers if requested (see **Section 6.5.2**), or the date any protest concerning this RFP is finally resolved. This period may be extended at the Procurement Officer's request only with the Offeror's written agreement.

4.12 Revisions to the RFP

4.12.1 If the RFP is revised before the due date for Proposals, the Department will post any addenda to the RFP on eMMA and will endeavor to provide such addenda to all prospective Offerors that were sent this RFP or are otherwise known by the Procurement Officer to have obtained this RFP. It remains the responsibility of all prospective Offerors to check eMMA for any addenda issued prior to the submission of Proposals.

4.12.2 Acknowledgment of the receipt of all addenda to this RFP issued before the Proposal due date will be included in the Transmittal Letter accompanying the Offeror's Technical Proposal.

4.12.3 Addenda made after the due date for Proposals will be sent only to those Offerors that remain under award consideration as of the issuance date of the addenda.

4.12.4 Acknowledgement of the receipt of addenda to the RFP issued after the Proposal due date will be in the manner specified in the addendum notice.

4.12.5 Failure to acknowledge receipt of an addendum does not relieve the Offeror from complying with the terms, additions, deletions, or corrections set forth in the addendum, and may cause the Proposal to be deemed not reasonably susceptible of being selected for award.

4.13 Cancellations

4.13.1 The State reserves the right to cancel this RFP, accept or reject any and all Proposals, in whole or in part, received in response to this RFP, waive or permit the cure of minor irregularities, and conduct discussions with all qualified or potentially qualified Offerors in any manner necessary to serve the best interests of the State.

4.13.2 The State reserves the right, in its sole discretion, to award a Contract based upon the written Proposals received without discussions or negotiations.

4.13.3 In the event a government entity proposes and receives the recommendation for award, the procurement may be cancelled and the award processed in accordance with COMAR 21.01.03.01.A(4).

4.13.4 If the services that are the subject of the RFP are currently being provided under an interagency agreement with a public institution of higher education and the State determines that the services can be provided more cost effectively by the public institution of higher education, then the RFP may be cancelled in accordance with Md. Code Ann., State Finance and Procurement Art., § 3-207(b)(2).

4.14 Incurred Expenses

The State will not be responsible for any costs incurred by any Offeror in preparing and submitting a Proposal, in making an oral presentation, providing a demonstration, or performing any other activities related to submitting a Proposal in response to this solicitation.

4.15 Protest/Disputes

Any protest or dispute related to this solicitation or the Contract award will be subject to the provisions of COMAR 21.10 (Administrative and Civil Remedies).

4.16 Offeror Responsibilities

4.16.1 Offerors must be able to provide all goods and services and meet all of the requirements requested in this solicitation and the successful Offeror will be responsible for Contract performance including any subcontractor participation.

4.16.2 All subcontractors will be identified and a complete description of their role relative to the Proposal will be included in the Offeror's Proposal. If applicable, subcontractors utilized in meeting the established MBE or VSBE participation goal(s) for this solicitation will be identified as provided in the appropriate Attachment(s) to this RFP (see **Section 4.26** "Minority Participation Goal" and **Section 4.27** "VSBE Goal").

4.16.3 If the Offeror is the subsidiary of another entity, all information submitted by the Offeror, including but not limited to references, financial reports, or experience and documentation (e.g. insurance policies, bonds, letters of credit) used to meet minimum qualifications, if any, will pertain exclusively to the Offeror, unless the parent organization will guarantee the performance of the subsidiary. If applicable, the Offeror's Proposal will contain an explicit statement, signed by an authorized representative of the parent organization, stating that the parent organization will guarantee the performance of the subsidiary.

4.16.4 A parental guarantee of the performance of the Offeror under this Section will not automatically result in crediting the Offeror with the experience or qualifications of the parent under any evaluation criteria pertaining to the actual Offeror's experience and qualifications. Instead, the Offeror will be evaluated on the extent to which the State determines that the experience and qualifications of the parent are applicable to and shared with the Offeror, any stated intent by the parent to be directly involved in the performance of the Contract, and the value of the parent's participation as determined by the State.

4.17 Acceptance of Terms and Conditions

By submitting a Proposal in response to this RFP, the Offeror, if selected for award, will be deemed to have accepted the terms and conditions of this RFP and the Contract, attached hereto as **Attachment M**. Any exceptions to this RFP or the Contract will be clearly identified in the Executive Summary of the Technical Proposal. **All exceptions will be taken into consideration when evaluating the Offeror's Proposal. The Department reserves the right to accept or reject any exceptions.**

4.18 Proposal Affidavit

A Proposal submitted by the Offeror must be accompanied by a completed Proposal Affidavit. A copy of this Affidavit is included as **Attachment C** of this RFP.

4.19 Contract Affidavit

All Offerors are advised that if a Contract is awarded as a result of this solicitation, the successful Offeror will be required to complete a Contract Affidavit. A copy of this Affidavit is included for informational purposes as **Attachment N** of this RFP. This Affidavit must be provided within five (5) Business Days of notification of recommended award. For purposes of completing Section "B" of this Affidavit (Certification of Registration or Qualification with the State Department of Assessments and Taxation), a business entity that is organized outside of the State of Maryland is considered a "foreign" business.

4.20 Compliance with Laws/Arrearages

By submitting a Proposal in response to this RFP, the Offeror, if selected for award, agrees that it will comply with all federal, State, and local laws applicable to its activities and obligations under the Contract.

By submitting a response to this solicitation, each Offeror represents that it is not in arrears in the payment of any obligations due and owing the State, including the payment of taxes and employee benefits, and will not become so in arrears during the term of the Contract if selected for Contract award.

4.21 Verification of Registration and Tax Payment

Before a business entity can do business in the State, it must be registered with the State Department of Assessments and Taxation (SDAT). SDAT is located at State Office Building, Room 803, 301 West Preston Street, Baltimore, Maryland 21201. For registration information, visit https://www.egov.maryland.gov/businessexpress.

It is strongly recommended that any potential Offeror complete registration prior to the Proposal due date and time. The Offeror's failure to complete registration with SDAT may disqualify an otherwise successful Offeror from final consideration and recommendation for Contract award.

4.22 False Statements

Offerors are advised that Md. Code Ann., State Finance and Procurement Article, § 11-205.1 provides as follows:

4.22.1 In connection with a procurement contract a person may not willfully:

A. Falsify, conceal, or suppress a material fact by any scheme or device.

B. Make a false or fraudulent statement or representation of a material fact.

C. Use a false writing or document that contains a false or fraudulent statement or entry of a material fact.

4.22.2 A person may not aid or conspire with another person to commit an act under **Section 4.22.1**.

4.22.3 A person who violates any provision of this section is guilty of a felony and on conviction is subject to a fine not exceeding $20,000 or imprisonment not exceeding five (5) years or both.

4.23 Payments by Electronic Funds Transfer

By submitting a Proposal in response to this solicitation, the Offeror, if selected for award:

4.23.1 Agrees to accept payments by electronic funds transfer (EFT) unless the State Comptroller's Office grants an exemption. Payment by EFT is mandatory for contracts exceeding $200,000. The successful Offeror will register using the COT/GAD X-10 Vendor Electronic Funds (EFT) Registration Request Form.

4.23.2 Any request for exemption must be submitted to the State Comptroller's Office for approval at the address specified on the COT/GAD X-10 form, must include the business identification information as stated on the form, and must include the reason for the exemption. The COT/GAD X-10 form may be downloaded from the Comptroller's website at:

http://comptroller.marylandtaxes.com/Vendor_Services/Accounting_Information/Static_Files/GADX10Form20150615.pdf.

4.24 Prompt Payment Policy

This procurement and the Contract(s) to be awarded pursuant to this solicitation are subject to the Prompt Payment Policy Directive issued by the Governor's Office of Small, Minority & Women Business Affairs (GOSBA) and dated August 1, 2008. Promulgated pursuant to Md. Code Ann., State Finance and Procurement Article, §§ 11-201, 13-205(a), and Title 14, Subtitle 3, and COMAR 21.01.01.03 and 21.11.03.01, the Directive seeks to ensure the prompt payment of all subcontractors on non-construction procurement contracts. The Contractor will comply with the prompt payment requirements outlined in the Contract, Section 31 "Prompt Pay Requirements" (see **Attachment M**). Additional information is available on GOSBA's website at: http://www.gomdsmallbiz.maryland.gov/documents/legislation/promptpaymentfaqs.pdf.

4.25 Electronic Procurements Authorized

4.25.1 Under COMAR 21.03.05, unless otherwise prohibited by law, the Administration may conduct procurement transactions by electronic means, including the solicitation, proposing, award, execution, and administration of a contract, as provided in Md. Code Ann., Maryland Uniform Electronic Transactions Act, Commercial Law Article, Title 21.

4.25.2 Participation in the solicitation process on a procurement contract for which electronic means has been authorized shall constitute consent by the Bidder to conduct by electronic means all elements of the procurement of that Contract which are specifically authorized under the solicitation or Contract. In the case of electronic transactions authorized by this IFB, electronic records and signatures by an authorized representative satisfy a requirement for written submission and signatures.

4.25.3 "Electronic means" refers to exchanges or communications using electronic, digital, magnetic, wireless, optical, electromagnetic, or other means of electronically conducting transactions. Electronic means includes e-mail, internet-based communications, electronic funds transfer, specific electronic bidding platforms (e.g., https://procurement.maryland.gov), and electronic data interchange.

4.25.4 In addition to specific electronic transactions specifically authorized in other sections of this solicitation (e.g., RFP § 4.23 describing payments by Electronic Funds Transfer), the following transactions are authorized to be conducted by electronic means on the terms as authorized in COMAR 21.03.05:

D. The Procurement Officer may conduct the procurement using eMMA or e-mail to issue:

1. The RFP;
2. Any amendments and requests for best and final offers;
3. Pre-Proposal conference documents;
4. Questions and responses;
5. Communications regarding the solicitation or Proposal to any Offeror or potential Offeror;
6. Notices of award selection or non-selection; and
7. The Procurement Officer's decision on any Proposal protest or Contract claim.

E. The Offeror or potential Offeror may use eMMA or e-mail to:

1) Submit initial proposals;

2) Ask questions regarding the solicitation;

3) Reply to any material received from the Procurement Officer by electronic means that includes a Procurement Officer's request or direction to reply by e-mail or through eMMA, but only on the terms specifically approved and directed by the Procurement Officer and;

4) Submit a "No Bid Notice/Vendor Feedback Form" to the IFB.

F. The Procurement Officer, the Contract Monitor, and the Contractor may conduct day-to-day Contract administration, except as outlined in **Section 4.25.5** of this subsection, utilizing e-mail or other electronic means if authorized by the Procurement Officer or Contract Monitor.

4.25.5 The following transactions related to this procurement and any Contract awarded pursuant to it are **not authorized** to be conducted by electronic means:

A. Filing of protests;

B. Filing of Contract claims;

C. Submission of documents determined by the Department to require original signatures (e.g., Contract execution, Contract modifications); or

D. Any transaction, submission, or communication where the Procurement Officer has specifically directed that a response from the Contractor or Bidder be provided in writing or hard copy.

4.25.6 Any e-mail transmission is only authorized to the e-mail addresses for the identified person as provided in the solicitation, the Contract, or in the direction from the Procurement Officer or Contract Monitor.

4.26 MBE Participation Goal

4.26.1 Establishment of Goal and Subgoals

An overall MBE subcontractor participation goal as identified in the Key Information Summary Sheet has been established for this procurement, representing a percentage of the total Contract dollar value, including all renewal option terms, if any, has been established for this procurement.

Notwithstanding any subgoals established for this RFP, the Contractor is encouraged to use a diverse group of subcontractors and suppliers from any/all of the various MBE classifications to meet the remainder of the overall MBE participation goal.

By submitting a response to this solicitation, the Offeror acknowledges the overall MBE subcontractor participation goal and subgoals, and commits to achieving the overall goal and subgoals by utilizing certified minority business enterprises, or requests a full or partial waiver of the overall goal and subgoals.

An Offeror that does not commit to meeting the entire MBE participation goal outlined in this Section 4.26 must submit a request for waiver with its proposal submission that is supported by good faith efforts documentation to meet the MBE goal made prior to submission of its proposal as outlined in Attachment D-1B, Waiver Guidance. Failure of an Offeror to properly complete, sign, and submit Attachment D-1A at the time it submits its Technical Response(s) to the RFP

will result in the State's rejection of the Offeror's Proposal for the applicable Service Category. This failure is not curable.

4.26.2 Attachments.

A. D-1 to D-5 – The following Minority Business Enterprise participation instructions, and forms are provided to assist Offerors:

1. Attachment D-1A MBE Utilization and Fair Solicitation Affidavit & MBE Participation Schedule (must be submitted with Proposal)
2. Attachment D-1B Waiver Guidance
3. Attachment D-1C Good Faith Efforts Documentation to Support Waiver Request
4. Attachment D-2 Outreach Efforts Compliance Statement
5. Attachment D-3A MBE Subcontractor Project Participation Certification
6. Attachment D-3B MBE Prime Project Participation Certification
7. Attachment D-4A Prime Contractor Paid/Unpaid MBE Invoice Report
8. Attachment D-4B MBE Prime Contractor Report
9. Attachment D-5 Subcontractor Paid/Unpaid MBE Invoice Report

B. The Offeror will include with its Proposal a completed MBE Utilization and Fair Solicitation Affidavit (**Attachment D-1A**) whereby:

1. The Offeror acknowledges the certified MBE participation goal and commits to make a good faith effort to achieve the goal and any applicable subgoals, or requests a waiver, and affirms that MBE subcontractors were treated fairly in the solicitation process; and
2. The Offeror responds to the expected degree of MBE participation, as stated in the solicitation, by identifying the specific commitment of certified MBEs at the time of Proposal submission. The Offeror will specify the percentage of total contract value associated with each MBE subcontractor identified on the MBE participation schedule, including any work performed by the MBE prime (including a prime participating as a joint venture) to be counted towards meeting the MBE participation goals.
3. The Offeror requesting a waiver should review **Attachment D-1B** (Waiver Guidance) and **D-1C** (Good Faith Efforts Documentation to Support Waiver Request) prior to submitting its request.

If the Offeror fails to submit a completed Attachment D-1A with the Proposal as required, the Procurement Officer will determine that the Proposal is not reasonably susceptible of being selected for award, unless the inaccuracy is determined to be the result of a minor irregularity that is waived or cured in accordance with COMAR 21.06.02.04.

4.26.3 Offerors are responsible for verifying that each MBE (including any MBE prime and MBE prime participating in a joint venture) selected to meet the goal and any subgoals and subsequently identified in **Attachment D-1A** is appropriately certified and has the correct NAICS codes allowing it to perform the committed work.

4.26.4 Within ten (10) Business Days from notification that it is the recommended awardee or from the date of the actual award, whichever is earlier, the Offeror must provide the following documentation to the Procurement Officer.

A. Outreach Efforts Compliance Statement (**Attachment D-2**);

B. MBE Subcontractor/Prime Project Participation Certification (**Attachment D-3A/3B**); and

C. Any other documentation required by the Procurement Officer to ascertain Offeror responsibility in connection with the certified MBE subcontractor participation goal or any applicable subgoals.

D. Further, if the recommended awardee believes a waiver (in whole or in part) of the overall MBE goal or of any applicable subgoal is necessary, the recommended awardee must submit a fully-documented waiver request that complies with COMAR 21.11.03.11.

If the recommended awardee fails to return each completed document within the required time, the Procurement Officer may determine that the recommended awardee is not responsible and, therefore, not eligible for Contract award. If the Contract has already been awarded, the award is voidable.

4.26.5 A current directory of certified MBEs is available through the Maryland State Department of Transportation (MDOT), Office of Minority Business Enterprise, 7201 Corporate Center Drive, Hanover, Maryland 21076. The phone numbers are (410) 865-1269, 1-800-544-6056, or TTY (410) 865-1342. The directory is also available on the MDOT website at http://mbe.mdot.maryland.gov/directory/. The most current and up-to-date information on MBEs is available via this website. **Only MDOT-certified MBEs may be used to meet the MBE subcontracting goals.**

4.26.6 The Offeror that requested a waiver of the goal or any of the applicable subgoals will be responsible for submitting the Good Faith Efforts Documentation to Support Waiver Request (**Attachment D-1C**) and all documentation within ten (10) Business Days from notification that it is the recommended awardee or from the date of the actual award, whichever is earlier, as required in COMAR 21.11.03.11.

4.26.7 All documents, including the MBE Utilization and Fair Solicitation Affidavit & MBE Participation Schedule (**Attachment D-1A**), completed and submitted by the Offeror in connection with its certified MBE participation commitment will be considered a part of the Contract and are hereby expressly incorporated into the Contract by reference thereto. All of the referenced documents will be considered a part of the Proposal for order of precedence purposes (see Contract – **Attachment M**, **Section 2.1**).

4.26.8 The Offeror is advised that liquidated damages will apply in the event the Contractor fails to comply in good faith with the requirements of the MBE program and pertinent Contract provisions. (See Contract – **Attachment M**, **Liquidated Damages for MBE, section 39**.

4.26.9 As set forth in COMAR 21.11.03.12-1(D), when a certified MBE firm participates on a contract as a prime contractor (including a joint-venture where the MBE firm is a partner), a procurement agency may count the distinct, clearly defined portion of the work of the contract that the certified MBE firm

performs with its own work force towards fulfilling up to fifty-percent (50%) of the MBE participation goal (overall) and up to one hundred percent (100%) of not more than one of the MBE participation subgoals, if any, established for the contract.

In order to receive credit for self-performance, an MBE prime must list its firm in Section 4A of the MBE Participation Schedule (**Attachment D-1A**) and include information regarding the work it will self-perform. For the remaining portion of the overall goal and the subgoals, the MBE prime must also identify other certified MBE subcontractors [see Section 4B of the MBE Participation Schedule (**Attachment D-1A**)] used to meet those goals. If dually-certified, the MBE prime can be designated as only one of the MBE subgoal classifications but can self-perform up to 100% of the stated subgoal.

As set forth in COMAR 21.11.03.12-1, once the Contract work begins, the work performed by a certified MBE firm, including an MBE prime, can only be counted towards the MBE participation goal(s) if the MBE firm is performing a commercially useful function on the Contract. Refer to MBE forms (**Attachment D**) for additional information.

4.27 VSBE Goal

4.27.1 Purpose

A. The Contractor will structure its procedures for the performance of the work required in the Contract to attempt to achieve the VSBE participation goal stated in this solicitation. VSBE performance must be in accordance with this section and **Attachment E**, as authorized by COMAR 21.11.13. The Contractor agrees to exercise all good faith efforts to carry out the requirements set forth in this section and **Attachment E**.

B. A certified Veteran-Owned Small Business Enterprises (VSBE) must be verified by the State Department of Veterans Affairs or US Department of Veteran's Affairs Vets First Verification Program (VetBiz) and registered as a VSBE on the State's eProcurement platform, eMaryland Marketplace Advantage (eMMA). The listing of VSBEs is available through the "Vendor Search" on eMMA.

4.27.2 VSBE Goal

A. A VSBE participation goal of the total Contract dollar amount has been established for this procurement as identified in the Key Information Summary Sheet.

B. By submitting a response to this solicitation, the Offeror agrees that this percentage of the total dollar amount of the Contract will be performed by verified veteran-owned small business enterprises.

4.27.3 Solicitation and Contract Formation

A. In accordance with COMAR 21.11.13.05 C (1), this solicitation requires Offerors to:

1. Identify specific work categories within the scope of the procurement appropriate for subcontracting;
2. Solicit VSBEs before Proposals are due, describing the identified work categories and providing instructions on how to bid on the subcontracts;
3. Attempt to make personal contact with the VSBEs solicited and to document these attempts;

4. Assist VSBEs to fulfill, or to seek waiver of, bonding requirements; and
5. Attempt to attend preProposal or other meetings the procurement agency schedules to publicize contracting opportunities to VSBEs.

B. The Offeror must include with its Proposal a completed VSBE Utilization Affidavit and Prime/Subcontractor Participation Schedule (Attachment E-1) whereby the Offeror:

1. Acknowledges it: a) intends to meet the VSBE participation goal; or b) requests a full or partial waiver of the VSBE participation goal. If the Offeror commits to the full VSBE goal or requests a partial waiver, it will commit to making a good faith effort to achieve the stated goal; and
2. Responds to the expected degree of VSBE participation as stated in the solicitation, by identifying the specific commitment of VSBEs at the time of Proposal submission. The Offeror will specify the percentage of contract value associated with each VSBE prime/subcontractor identified on the VSBE Participation Schedule.

C. As set forth in COMAR 21.11.13.05.B(2), when a verified VSBE firm participates on a Contract as a Prime Contractor, a procurement agency may count the distinct, clearly defined portion of the work of the contract that the VSBE Prime Contractor performs with its own work force towards meeting up to one hundred percent (100%) of the VSBE goal.

D. In order to receive credit for self-performance, a VSBE Prime must list its firm in the VSBE Prime/Subcontractor Participation Schedule (**Attachment E-1**) and include information regarding the work it will self-perform. For any remaining portion of the VSBE goal that is not to be performed by the VSBE Prime, the VSBE Prime must also identify verified VSBE subcontractors used to meet the remainder of the goal.

E. Within 10 Business Days from notification that it is the apparent awardee, the awardee must provide the following documentation to the Procurement Officer:

1. VSBE Project Participation Statement (Attachment E-2);
2. If the apparent awardee believes a full or partial waiver of the overall VSBE goal is necessary, it must submit a fully-documented waiver request that complies with COMAR 21.11.13.07; and
3. Any other documentation required by the Procurement Officer to ascertain Offeror responsibility in connection with the VSBE participation goal.

If the apparent awardee fails to return each completed document within the required time, the Procurement Officer may determine that the apparent awardee is not reasonably susceptible of being selected for award.

4.28 Living Wage Requirements

A. Maryland law requires that contractors meeting certain conditions pay a living wage to covered employees on State service contracts over $100,000. Maryland Code Ann., State Finance and Procurement Article, § 18-101 et al. The Commissioner of Labor and Industry at the Department of Labor, Licensing and

Regulation requires that a contractor subject to the Living Wage law submit payroll records for covered employees and a signed statement indicating that it paid a living wage to covered employees; or receive a waiver from Living Wage reporting requirements. See COMAR 21.11.10.05.

B. If subject to the Living Wage law, Contractor agrees that it will abide by all Living Wage law requirements, including but not limited to reporting requirements in COMAR 21.11.10.05. Contractor understands that failure of Contractor to provide such documents is a material breach of the terms and conditions and may result in Contract termination, disqualification by the State from participating in State contracts, and other sanctions. Information pertaining to reporting obligations may be found by going to the Maryland Department of Labor, Licensing and Regulation (DLLR) website http://www.dllr.state.md.us/labor/prev/livingwage.shtml

C. Additional information regarding the State's living wage requirement is contained in **Attachment F**. Offerors must complete and submit the Maryland Living Wage Requirements Affidavit of Agreement (**Attachment F-1**) with their Proposals. If the Offeror fails to complete and submit the required documentation, the State may determine the Offeror to not be responsible under State law.

D. Contractors and subcontractors subject to the Living Wage Law will pay each covered employee at least the minimum amount set by law for the applicable Tier area. The specific living wage rate is determined by whether a majority of services take place in a Tier 1 Area or a Tier 2 Area of the State. The specific Living Wage rate is determined by whether a majority of services take place in a Tier 1 Area or Tier 2 Area of the State.

1. The Tier 1 Area includes Montgomery, Prince George's, Howard, Anne Arundel and Baltimore Counties, and Baltimore City. The Tier 2 Area includes any county in the State not included in the Tier 1 Area. In the event that the employees who perform the services are not located in the State, the head of the unit responsible for a State Contract pursuant to §18-102(d) of the State Finance and Procurement Article will assign the tier based upon where the recipients of the services are located. If the Contractor provides more than 50% of the services from an out-of-State location, the State agency determines the wage tier based on where the majority of the service recipients are located. In this circumstance, the Contract will be determined to be a Tier (enter "1" or "2," depending on where the majority of the service recipients are located) Contract.

2. The Contract will be determined to be a Tier 1 Contract or a Tier 2 Contract depending on the location(s) from which the Contractor provides 50% or more of the services. The Offeror must identify in its Proposal the location(s) from which services will be provided, including the location(s) from which 50% or more of the Contract services will be provided.

3. If the Contractor provides 50% or more of the services from a location(s) in a Tier 1 jurisdiction(s) the Contract will be a Tier 1 Contract.

4. If the Contractor provides 50% or more of the services from a location(s) in a Tier 2 jurisdiction(s), the Contract will be a Tier 2 Contract.

E. If the Contractor provides more than 50% of the services from an out-of-State location, the State agency determines the wage tier based on where the majority of the service recipients are located. See COMAR 21.11.10.07.

F. The Offeror will identify in the Proposal the location from which services will be provided.

G. **NOTE:** Whereas the Living Wage may change annually, the Contract price will not change because of a Living Wage change.

4.29 Federal Funding Acknowledgement

4.29.1 There are programmatic conditions that apply to the Contract due to federal funding (see **Attachment G**).

4.29.2 The total amount of federal funds allocated for the Medical Care Programs is $6,160,000.00 in Maryland State fiscal year 2021. This represents 59.4% of all funds budgeted for the unit in that fiscal year. This does not necessarily represent the amount of funding available for any particular grant, contract, or solicitation.

4.29.3 The Contract contains federal funds. The source of these federal funds is: Title XIX. The CFDA number is 93.778:. The conditions that apply to all federal funds awarded by the Department are contained in Federal Funds **Attachment G**. Any additional conditions that apply to this particular federally-funded contract are contained as supplements to Federal Funds **Attachment G** and Offerors are to complete and submit these Attachments with their Proposals as instructed in the Attachments. Acceptance of this agreement indicates the Offeror's intent to comply with all conditions, which are part of the Contract.

4.30 Conflict of Interest Affidavit and Disclosure

4.30.1 The Offeror will complete and sign the Conflict of Interest Affidavit and Disclosure (**Attachment H**) and submit it with its Proposal.

4.30.2 By submitting a Conflict of Interest Affidavit and Disclosure, the Contractor will be construed as certifying all Contractor Personnel and subcontractors are also without a conflict of interest as defined in COMAR 21.05.08.08A.

4.30.3 Additionally, a Contractor has an ongoing obligation to ensure that all Contractor Personnel are without conflicts of interest prior to providing services under the Contract. For policies and procedures applying specifically to Conflict of Interests, the Contract is governed by COMAR 21.05.08.08.

4.30.4 Participation in Drafting of Specifications: Disqualifying Event: Offerors are advised that Md. Code Ann. State Finance and Procurement Article §13-212.1(a) provides generally that "an individual who assists an executive unit in the drafting of specifications, an invitation for bids, a request for proposals for a procurement, or the selection or award made in response to an invitation for bids or a request for proposals, or a person that employs the individual, may not: (1) submit a bid or proposal for that procurement; or (2) assist or represent another person, directly or indirectly, who is submitting a bid or proposal for that procurement." Any Offeror submitting a Proposal in violation of this provision will be classified as "not responsible." See COMAR 21.05.03.03.

4.31 Non-Disclosure Agreement

4.31.1 Non-Disclosure Agreement (Offeror)

A Non-Disclosure Agreement (Offeror) is not required for this procurement.

4.31.2 Non-Disclosure Agreement (Contractor)

All Offerors are advised that this solicitation and any Contract(s) are subject to the terms of the Non-Disclosure Agreement (NDA) contained in this solicitation as **Attachment I**. This Agreement must be provided within five (5) Business Days of notification of recommended award; however, to expedite processing, it is suggested that this document be completed and submitted with the Proposal.

4.32 HIPAA - Business Associate Agreement

Based on the determination by the Department that the functions to be performed in accordance with this solicitation constitute Business Associate functions as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the recommended awardee will execute a Business Associate Agreement as required by HIPAA regulations at 45 C.F.R. §164.500 *et seq.* and set forth in **Attachment J**. This Agreement must be provided within five (5) Business Days of notification of proposed Contract award. However, to expedite processing, it is suggested that this document be completed and submitted with the Proposal. Should the Business Associate Agreement not be submitted upon expiration of the five (5) Business Day period as required by this solicitation, the Procurement Officer, upon review of the Office of the Attorney General and approval of the Secretary, may withdraw the recommendation for award and make the award to the responsible Offeror with the next highest overall-ranked Proposal.

4.33 Nonvisual Access

4.33.1 The bidder or offeror warrants that the information technology offered under this bid or proposal (1) provides equivalent access for effective use by both visual and nonvisual means consistent with the standards of § 508 of the federal Rehabilitation Act of 1973 and Code of Maryland Regulations 14.33.02; (2) provides an individual with disabilities with nonvisual access in a way that is fully and equally accessible to and independently usable by the individual with disabilities so that the individual is able to acquire the same information, engage in the same interactions, and enjoy the same services as users without disabilities, with substantially equivalent ease of use; (3) will present information, including prompts used for interactive communications, in formats intended for both visual and nonvisual use; (4) if intended for use in a network, can be integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired; and (5) is available, whenever possible, without modification for compatibility with software and hardware for nonvisual access. The bidder or offeror further warrants that the cost, if any, of modifying the information technology for compatibility with software and hardware used for nonvisual access will not increase the cost of the information technology by more than 15 percent.

If the information technology procured under this solicitation does not meet the nonvisual access standards set forth in the Code of Maryland Regulations 14.33.02, the State will notify the bidder or offeror in writing that the bidder or offeror, at its own expense, has 12 months after the date of the notification to modify the information technology in order to meet the nonvisual access standards. If the bidder or offeror fails to modify the information technology to meet the nonvisual access standards within 12 months after the date of the notification, the bidder or offeror may be subject to a civil penalty

of a fine not exceeding $5,000 for a first offense, and a fine not exceeding $10,000 for a subsequent offense.

The bidder or offeror shall indemnify the State for liability resulting from the use of information technology that does not meet the applicable nonvisual access standards.

4.34 For purposes of this regulation, the phrase ‘equivalent access' means the ability to receive, use, and manipulate information and operate controls necessary to access and use information technology by nonvisual means. Examples of equivalent access include keyboard controls used for input and synthesized speech, Braille, or other audible or tactile means used for output.Mercury and Products That Contain Mercury

This solicitation does not include the procurement of products known to likely include mercury as a component.

4.35 Location of the Performance of Services Disclosure

The Offeror is required to complete the Location of the Performance of Services Disclosure. A copy of this Disclosure is included as **Attachment L**. The Disclosure must be provided with the Proposal.

Services under this Contract must be performed in the United States.

4.36 Department of Human Services (DHS) Hiring Agreement

All Offerors are advised that if a Contract is awarded as a result of this solicitation, the successful Offeror will be required to complete a DHS Hiring Agreement. A copy of this Agreement is included as **Attachment O**. This Agreement must be provided within five (5) Business Days of notification of recommended award.

4.37 Small Business Reserve (SBR) Procurement

This solicitation is not designated as a Small Business Reserve (SBR) Procurement.

4.38 Maryland Healthy Working Families Act Requirements

On February 11, 2018, the Maryland Healthy Working Families Act went into effect. All offerors should be aware of how this Act could affect your potential contract award with the State of Maryland. See the Department of Labor, Licensing and Regulations web site for Maryland Healthy Working Families Act Information: http://dllr.maryland.gov/paidleave/.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

5 Proposal Format

5.1 Two Part Submission

Offerors will submit Proposals in separate volumes:

- Volume I –Technical Proposal
- Volume II – Financial Proposal

5.2 Proposal Delivery and Packaging

5.2.1 Proposals delivered by eMMA and e-mail will be considered

5.2.2 Provide no pricing information in the Technical Proposal. Provide no pricing information on the media submitted in the Technical Proposal.

5.2.3 Offerors shall submit Proposals online via eMaryland Marketplace Advantage (eMMA) as described below to the weblink provided in the Key Information Summary Sheet.

5.2.4 Instructions on how to submit proposals electronically can be found at: https://procurement.maryland.gov/wp-content/uploads/sites/12/2019/08/5-eMMA-QRG-Responding-to-Solicitations-Double-Envelope-v2.pdf

5.2.5 The Procurement Officer must receive all Proposal material by the RFP due date and time specified in the Key Information Summary Sheet. Requests for extension of this date or time will not be granted. Offerors shall not be permitted to deliver a hard copy (paper) Proposal to the Procurement Officer. Except as provided in COMAR 21.05.03.02F, Proposals received by the Procurement Officer after the due date will not be considered.

5.2.6 The Procurement Officer will only contact those Offerors with Proposals that are reasonably susceptible for award for participation in activities beyond the due date and time for receipt of proposals.

5.2.7 Offerors shall provide their Proposals in two separately sealed and labeled packages as follows:

a) Volume I - Technical Proposal consisting of:

1) One (1) original electronic version of the Technical Proposal and all supporting material in Microsoft Word format, version 2007 or greater,

2) One (1) Technical Proposal in searchable Adobe PDF format, and

3) One (1) searchable Adobe PDF copy of the Technical Proposal with confidential and proprietary information redacted (see **Section 4.8**).

b) Volume II - Financial Proposal consisting of:

1) One (1) original electronic version of the Financial Proposal and all supporting material in Microsoft Excel format, version 2007 or greater.

2) One (1) original searchable Adobe pdf copy of the Financial Proposal, (see **Section 4.8**).

3) One (1) searchable Adobe pdf copy of the Financial Proposal, with confidential and proprietary information redacted (see **Section 4.8**)

5.3 Volume I - Technical Proposal

NOTE: Omit all **pricing information** from the Technical Proposal (Volume I). Include pricing information only in the Financial Proposal (Volume II).

5.3.1 In addition to the instructions below, responses in the Offeror's Technical Proposal will reference the organization and numbering of Sections in the RFP (e.g., "Section 2.2.1 Response . . .; "Section 2.2.2 Response . . .,"). All pages of both Proposal volumes will be consecutively numbered from beginning (Page 1) to end (Page "x").

5.3.2 The Technical Proposal will include the following documents and information in the order specified as follows. Each section of the Technical Proposal will be separated by a TAB as detailed below:

A. Title Page and Table of Contents (Submit under TAB A)

The Technical Proposal should begin with a Title Page bearing the name and address of the Offeror and the name and number of this RFP. A Table of Contents will follow the Title Page for the Technical Proposal, organized by section, subsection, and page number.

B. Claim of Confidentiality (If applicable, submit under TAB A-1)

Any information which is claimed to be confidential and/or proprietary information should be identified by page and section number and placed after the Title Page and before the Table of Contents in the Technical Proposal, and if applicable, separately in the Financial Proposal. An explanation for each claim of confidentiality will be included (see **Section 4.8 "Public Information Act Notice"**). The entire Proposal cannot be given a blanket confidentiality designation - any confidentiality designation must apply to specific sections, pages, or portions of pages of the Proposal and an explanation for each claim will be included.

C. Offeror Information Sheet and Transmittal Letter (Submit under TAB B)

The Offeror Information Sheet (see **Appendix 2**) and a Transmittal Letter will accompany the Technical Proposal. The purpose of the Transmittal Letter is to transmit the Proposal and acknowledge the receipt of any addenda to this RFP issued before the Proposal due date and time. Transmittal Letter should be brief, be signed by an individual who is authorized to commit the Offeror to its Proposal and the requirements as stated in this RFP.

D. Executive Summary (Submit under TAB C)

The Offeror will condense and highlight the contents of the Technical Proposal in a separate section titled "Executive Summary."

In addition, the Summary will indicate whether the Offeror is the subsidiary of another entity, and if so, whether all information submitted by the Offeror pertains exclusively to the Offeror. If not, the subsidiary Offeror will include a guarantee of performance from its parent organization as part of its Executive Summary (see **Section 4.16 "Offeror Responsibilities"**).

The Executive Summary will also identify any exceptions the Offeror has taken to the requirements of this RFP, the Contract (**Attachment M**), or any other exhibits or attachments. Acceptance or rejection of exceptions is within the sole discretion of the State. **Exceptions to terms and conditions, including requirements, may result in having the Proposal deemed unacceptable or classified as not reasonably susceptible of being selected for award.**

E. Minimum Qualifications Documentation (If applicable, Submit under TAB D)

The Offeror will submit any Minimum Qualifications documentation that may be required, as set forth in RFP **Section 1**. If references are required in **RFP Section 1**, those references will be submitted in this section and will contain the information described in both **Section 1** and **Section 5.3.2.I**.

F. Offeror Technical Response to RFP Requirements and Proposed Work Plan (Submit under TAB E)

1. The Offeror will address each RFP requirement (RFP **Section 2** and **Section 3**) in its Technical Proposal with a cross reference to the requirement and describe how its proposed goods and services, including the goods and services of any proposed subcontractor(s), will meet or exceed the requirement(s). If the State is seeking Offeror agreement to any requirement(s), the Offeror will state its agreement or disagreement. Any paragraph in the Technical Proposal that responds to an RFP requirement will include an explanation of how the work will be performed. The response will address each requirement in **Section 2** and **Section 3** in order, and will contain a cross reference to the requirement.
2. Any exception to a requirement, term, or condition may result in having the Proposal classified as not reasonably susceptible of being selected for award or the Offeror deemed not responsible.
3. The Offeror will give a definitive section-by-section description of the proposed plan to meet the requirements of the RFP, i.e., a Work Plan. The Work Plan will include the specific methodology, techniques, and number of staff, if applicable, to be used by the Offeror in providing the required goods and services as outlined in RFP **Section 2**, Contractor Requirements: Scope of Work. The description will include an outline of the overall management concepts employed by the Offeror and a project management plan, including project control mechanisms and overall timelines. Project deadlines considered contract deliverables must be recognized in the Work Plan.
4. Implementation Schedule - Offeror will provide the proposed implementation schedule with its Proposal.
5. The Offeror will provide a draft Problem Escalation Procedure (PEP) that includes, at a minimum, titles of individuals to be contacted by the Contract Monitor should problems arise under the Contract and explains how problems with work under the Contract will be escalated in order to resolve any issues in a timely manner. Final procedures will be submitted as indicated in **Section 3.8**.
6. Disaster Recovery and Security Model description - For hosted services, the Offeror will include its DR strategy, and for on premise, a description of a recommended DR strategy.
7. The Offeror will include a deliverable description and schedule describing the proposed Deliverables as mapped to the State SDLC and the Deliverables table in **Section 2.4.4**. The schedule will also detail proposed submission due date/frequency of each recommended Deliverable.

G. Experience and Qualifications of Proposed Staff (Submit under TAB F)

The Offeror will identify the qualifications and types of staff proposed to be utilized under the Contract including information in support of the Personnel Experience criteria in **Section 3.10.2**. Specifically, the Offeror will:

1. Describe in detail how the proposed staff's experience and qualifications relate to their specific responsibilities, including any staff of proposed subcontractor(s), as detailed in the Work Plan.
2. Include individual resumes for Key Personnel, including Key Personnel for any proposed subcontractor(s), who are to be assigned to the project if the Offeror is awarded the Contract. Each resume should include the amount of experience the individual has had relative to the Scope of Work set forth in this solicitation.
3. Include letters of intended commitment to work on the project, including letters from any proposed subcontractor(s). Offerors should be aware of restrictions on substitution of Key Personnel prior to RFP award (see Substitution Prior to and Within 30 Days After Contract Execution in Section 3.11.5).
4. Provide an Organizational Chart outlining Personnel and their related duties. The Offeror will include job titles and the percentage of time each individual will spend on his/her assigned tasks. Offerors using job titles other than those commonly used by industry standards must provide a crosswalk reference document.
5. If proposing differing personnel work hours than identified in the RFP, describe how and why it proposes differing personnel work hours.

H. Offeror Qualifications and Capabilities (Submit under TAB G)

The Offeror will include information on past experience with similar projects and services including information in support of the Offeror Experience criteria in **Section 3.10.1**. The Offeror will describe how its organization can meet the requirements of this RFP and will also include the following information:

1) The number of years the Offeror has provided the similar goods and services;
2) The number of clients/customers and geographic locations that the Offeror currently serves;
3) The names and titles of headquarters or regional management personnel who may be involved with supervising the services to be performed under the Contract;
4) The Offeror's process for resolving billing errors; and
5) An organizational chart that identifies the complete structure of the Offeror including any parent company, headquarters, regional offices, and subsidiaries of the Offeror.

I. References (Submit under TAB H)

At least three (3) references are requested from customers who are capable of documenting the Offeror's ability to provide the goods and services specified in this RFP. References used to meet any Minimum Qualifications (see RFP **Section 1**) may be used to meet this request. Each reference will be from a client for whom the Offeror has provided goods and services within the past five (5) years and will include the following information:

1. Name of client organization;
2. Name, title, telephone number, and e-mail address, if available, of point of contact for client organization; and
3. Value, type, duration, and description of goods and services provided.

The Department reserves the right to request additional references or utilize references not provided by the Offeror. Points of contact must be accessible and knowledgeable regarding Offeror performance.

J. List of Current or Prior State Contracts (Submit under TAB I)

Provide a list of all contracts with any entity of the State of Maryland for which the Offeror is currently performing goods and services or for which services have been completed within the last five (5) years. For each identified contract, the Offeror is to provide:

1. The State contracting entity;
2. A brief description of the goods and services provided;
3. The dollar value of the contract;
4. The term of the contract;
5. The State employee contact person (name, title, telephone number, and, if possible, e-mail address); and
6. Whether the contract was terminated before the end of the term specified in the original contract, including whether any available renewal option was not exercised.

Information obtained regarding the Offeror's level of performance on State contracts will be used by the Procurement Officer to determine the responsibility of the Offeror and considered as part of the experience and past performance evaluation criteria of the RFP.

K. Financial Capability (Submit under TAB J)

The Offeror must include in its Proposal a commonly-accepted method to prove its fiscal integrity. If available, the Offeror will include Financial Statements, preferably a Profit and Loss (P&L) statement and a Balance Sheet, for the last two (2) years (independently audited preferred).

In addition, the Offeror may supplement its response to this Section by including one or more of the following with its response:

1. Dun & Bradstreet Rating;
2. Standard and Poor's Rating;
3. Lines of credit;
4. Evidence of a successful financial track record; and
5. Evidence of adequate working capital.

L. Certificate of Insurance (Submit under TAB K)

The Offeror will provide a copy of its current certificate of insurance showing the types and limits of insurance in effect as of the Proposal submission date. The current insurance types and limits do not have to be the same as described in **Section 3.6**. See **Section 3.6** for the required insurance certificate submission for the apparent awardee.

M. Subcontractors (Submit under TAB L)

The Offeror will provide a complete list of all subcontractors that will work on the Contract if the Offeror receives an award, including those utilized in meeting the MBE and VSBE subcontracting goal(s), if applicable. This list will include a full description of the duties each subcontractor will perform and why/how each subcontractor was deemed the most qualified

for this project. If applicable, subcontractors utilized in meeting the established MBE or VSBE participation goal(s) for this solicitation will be identified as provided in the appropriate attachment(s) of this RFP.

N. Legal Action Summary (Submit under TAB M)

This summary will include:

1. A statement as to whether there are any outstanding legal actions or potential claims against the Offeror and a brief description of any action;
2. A brief description of any settled or closed legal actions or claims against the Offeror over the past five (5) years;
3. A description of any judgments against the Offeror within the past five (5) years, including the court, case name, complaint number, and a brief description of the final ruling or determination; and
4. In instances where litigation is ongoing and the Offeror has been directed not to disclose information by the court, provide the name of the judge and location of the court.

O. Economic Benefit Factors (Submit under TAB N)

1. The Offeror will submit with its Proposal a narrative describing benefits that will accrue to the Maryland economy as a direct or indirect result of its performance of the Contract. Proposals will be evaluated to assess the benefit to Maryland's economy specifically offered. The economic benefit offered should be consistent with the Offeror's Total Proposal Price from **Attachment B**, the Financial Proposal Form. See COMAR 21.05.03.03A (3).
2. Proposals that identify specific benefits as being contractually enforceable commitments will be rated more favorably than Proposals that do not identify specific benefits as contractual commitments, all other factors being equal.
3. Offerors will identify any performance guarantees that will be enforceable by the State if the full level of promised benefit is not achieved during the Contract term.
4. As applicable, for the full duration of the Contract, including any renewal period, or until the commitment is satisfied, the Contractor will provide to the Procurement Officer or other designated agency personnel reports of the actual attainment of each benefit listed in response to this section. These benefit attainment reports will be provided quarterly, unless elsewhere in these specifications a different reporting frequency is stated.
5. In responding to this section, the following do not generally constitute economic benefits to be derived from the Contract:
    a) generic statements that the State will benefit from the Offeror's superior performance under the Contract;
    b) descriptions of the number of Offeror employees located in Maryland other than those that will be performing work under the Contract; or

c) tax revenues from Maryland-based employees or locations, other than those that will be performing, or used to perform, work under the Contract.

6. Discussion of Maryland-based employees or locations may be appropriate if the Offeror makes some projection or guarantee of increased or retained presence based upon being awarded the Contract.

7. Examples of economic benefits to be derived from a contract may include any of the following. For each factor identified below, identify the specific benefit and contractual commitments and provide a breakdown of expenditures in that category:

a) The Contract dollars to be recycled into Maryland's economy in support of the Contract, through the use of Maryland subcontractors, suppliers and joint venture partners. **Do not include actual fees or rates paid to subcontractors or information from your Financial Proposal;**

b) The number and types of jobs for Maryland residents resulting from the Contract. Indicate job classifications, number of employees in each classification and the aggregate payroll to which the Offeror has committed, including contractual commitments at both prime and, if applicable, subcontract levels; and whether Maryland employees working at least 30 hours per week and are employed at least 120 days during a 12-month period will receive paid leave. If no new positions or subcontracts are anticipated as a result of the Contract, so state explicitly;

c) Tax revenues to be generated for Maryland and its political subdivisions as a result of the Contract. Indicate tax category (sales taxes, payroll taxes, inventory taxes and estimated personal income taxes for new employees). Provide a forecast of the total tax revenues resulting from the Contract;

d) Subcontract dollars committed to Maryland small businesses and MBEs; and

e) Other benefits to the Maryland economy which the Offeror promises will result from awarding the Contract to the Offeror, including contractual commitments. Describe the benefit, its value to the Maryland economy, and how it will result from, or because of the Contract award. Offerors may commit to benefits that are not directly attributable to the Contract, but for which the Contract award may serve as a catalyst or impetus.

P. Technical Proposal - Required Forms and Certifications (Submit under TAB O)

1) All forms required for the Technical Proposal are identified in Table 1 of **Section 7** – RFP Attachments and Appendices. Unless directed otherwise by instructions within an individual form, complete, sign, and include all required forms in the Technical Proposal, under TAB O.

2) Offerors will furnish any and all agreements and terms and conditions the Offeror expects the State to sign or to be subject to in connection with or in order to use the Offeror's

services under this Contract. This includes physical copies of all agreements referenced and incorporated in primary documents, including but not limited to any software licensing agreement for any software proposed to be licensed to the State under this Contract (e.g., EULA, Enterprise License Agreements, Professional Service agreement, Master Agreement) and any AUP. The State does not agree to terms and conditions not provided in an Offeror's Technical Proposal and no action of the State, including but not limited to the use of any such software, will be deemed to constitute acceptance of any such terms and conditions. Failure to comply with this section renders any such agreement unenforceable against the State.

3) For each service, hardware or software proposed as furnished by a third-party entity, Offeror must identify the third-party provider and provide a letter of authorization or such other documentation demonstrating the authorization for such services. In the case of an open source license, authorization for the open source will demonstrate compliance with the open source license.

4) A Letter of Authorization will be on letterhead or through the provider's e-mail. Further, each Letter of Authorization will be less than twelve (12) months old and must provide the following information:

   i) Third-party POC name and alternate for verification

   ii) Third-party POC mailing address

   iii) Third-party POC telephone number

   iv) Third-party POC email address

   v) If available, a Re-Seller Identifier

5.4 Volume II – Financial Proposal

The Financial Proposal will contain all price information in the format specified in **Attachment B**. The Offeror will complete the Financial Proposal Form only as provided in the Financial Proposal Instructions and the Financial Proposal Form itself. Do not amend, alter, or leave blank any items on the Financial Proposal Form or include additional clarifying or contingent language on or attached to the Financial Proposal Form. Failure to adhere to any of these instructions may result in the Proposal being determined to be not reasonably susceptible of being selected for award and rejected by the Department.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

6 Evaluation and Selection Process

6.1 Evaluation Committee

Evaluation of Proposals will be performed in accordance with COMAR 21.05.03 by a committee established for that purpose and based on the evaluation criteria set forth below. The Evaluation Committee will review Proposals, participate in Offeror oral presentations and discussions, and provide input to the Procurement Officer. The Department reserves the right to utilize the services of individuals outside of the established Evaluation Committee for advice and assistance, as deemed appropriate.

During the evaluation process, the Procurement Officer may determine at any time that a particular Offeror is not susceptible for award.

6.2 Technical Proposal Evaluation Criteria

The criteria to be used to evaluate each Technical Proposal are listed below in descending order of importance. Unless stated otherwise, any sub-criteria within each criterion have equal weight.

6.2.1 Offeror's Technical Response to Requirements and Work Plan (See RFP **§ 5.3.2.F**)

The State prefers the Offeror's Technical Proposal to illustrate a comprehensive understanding of work requirements and mastery of the subject matter, including an explanation of how the work will be performed. Proposals which include limited responses to work requirements such as "concur" or "will comply" will receive a lower ranking than those Proposals that demonstrate an understanding of the work requirements and include plans to meet or exceed them.

6.2.2 Experience and Qualifications of Proposed Staff (See RFP **§ 5.3.2.G**)

6.2.3 Offeror Qualifications and Capabilities, including proposed subcontractors (See RFP **§ 5.3.2.H**)

6.2.4 Economic Benefit to State of Maryland (See RFP **§ 5.3.2.O**) [[Delete if removed from 5.3.2. Double check the cross reference.]]

6.3 Financial Proposal Evaluation Criteria

All Qualified Offerors (see **Section 6.5.2.D**) will be ranked from the lowest (most advantageous) to the highest (least advantageous) price based on the Total Proposal Price within the stated guidelines set forth in this RFP and as submitted on **Attachment B** - Financial Proposal Form.

6.4 Reciprocal Preference

6.4.1 Although Maryland law does not authorize procuring agencies to favor resident Offerors in awarding procurement contracts, many other states do grant their resident businesses preferences over Maryland contractors. COMAR 21.05.01.04 permits procuring agencies to apply a reciprocal preference under the following conditions:

A. The Maryland resident business is a responsible Offeror;

B. The most advantageous Proposal is from a responsible Offeror whose principal office, or principal base of operations is in another state;

C. The other state gives a preference to its resident businesses through law, policy, or practice; and

D. The preference does not conflict with a federal law or grant affecting the procurement Contract.

6.4.2 The preference given will be identical to the preference that the other state, through law, policy, or practice gives to its resident businesses.

6.5 Selection Procedures

6.5.1 General

A. The Contract will be awarded in accordance with the Competitive Sealed Proposals (CSP) method found at COMAR 21.05.03. The CSP method allows for the conducting of discussions and the revision of Proposals during these discussions. Therefore, the State may conduct discussions with all Offerors that have submitted Proposals that are determined to be reasonably susceptible of being selected for contract award or potentially so. However, the State reserves the right to make an award without holding discussions.

B. With or without discussions, the State may determine the Offeror to be not responsible or the Offeror's Proposal to be not reasonably susceptible of being selected for award at any time after the initial closing date for receipt of Proposals and prior to Contract award.

6.5.2 Selection Process Sequence

A. A determination is made that the MDOT Certified MBE Utilization and Fair Solicitation Affidavit (**Attachment D-1A**) is included and is properly completed, if there is a MBE goal. In addition, a determination is made that the VSBE Utilization Affidavit and subcontractor Participation Schedule (**Attachment E-1**) is included and is properly completed, if there is a VSBE goal.

B. Technical Proposals are evaluated for technical merit and ranked. During this review, oral presentations and discussions may be held. The purpose of such discussions will be to assure a full understanding of the State's requirements and the Offeror's ability to perform the services, as well as to facilitate arrival at a Contract that is most advantageous to the State. Offerors will be contacted by the State as soon as any discussions are scheduled.

C. Offerors must confirm in writing any substantive oral clarifications of, or changes in, their Technical Proposals made in the course of discussions. Any such written clarifications or changes then become part of the Offeror's Technical Proposal. Technical Proposals are given a final review and ranked.

D. The Financial Proposal of each Qualified Offeror (a responsible Offeror determined to have submitted an acceptable Proposal) will be evaluated and ranked separately from the Technical evaluation. After a review of the Financial Proposals of Qualified Offerors, the Evaluation Committee or Procurement Officer may again conduct discussions to further evaluate the Offeror's entire Proposal.

E. When in the best interest of the State, the Procurement Officer may permit Qualified Offerors to revise their initial Proposals and submit, in writing, Best and Final Offers (BAFOs). The State may make an award without issuing a request for a BAFO. Offerors may only perform limited substitutions of proposed personnel as allowed in Section 3.11 (Substitution of Personnel).

6.5.3 Award Determination

Upon completion of the Technical Proposal and Financial Proposal evaluations and rankings, each Offeror will receive an overall ranking. The Procurement Officer will recommend award of the Contract to the responsible Offeror that submitted the Proposal determined to be the most advantageous to the State. In making this most advantageous Proposal determination, technical factors will receive equal weight with financial factors.

6.6 Documents Required upon Notice of Recommendation for Contract Award

Upon receipt of a Notification of Recommendation for Contract award, the apparent awardee will complete and furnish the documents and attestations as directed in Table 1 of **Section 7** – **RFP Attachments and Appendices**.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

7 RFP ATTACHMENTS AND APPENDICES

Instructions Page

A Proposal submitted by the Offeror must be accompanied by the completed forms and/or affidavits identified as "with Proposal" in the "When to Submit" column in Table 1 below. All forms and affidavits applicable to this RFP, including any applicable instructions and/or terms, are identified in the "Applies" and "Label" columns in Table 1.

For documents required as part of the Proposal:

1. For e-mail submissions, submit one (1) copy of each with signatures.
2. For paper submissions, submit two (2) copies of each with original signatures. All signatures must be clearly visible.

All Offerors are advised that if a Contract is awarded as a result of this solicitation, the successful Offeror will be required to complete certain forms and affidavits after notification of recommended award. The list of forms and affidavits that must be provided is described in Table 1 below in the "When to Submit" column.

For documents required after award, submit one (1) copy of each document within the appropriate number of days after notification of recommended award, as listed in Table 1 below in the "When to Submit" column.

Table 1: RFP ATTACHMENTS AND APPENDICES

Applies?	When to Submit	Label	Attachment Name
Y	Before Proposal	A	Pre-Proposal Conference Response Form
Y	With Proposal	B	Financial Proposal Instructions and Form
Y	With Proposal	C	Bid/Proposal Affidavit (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentC-Bid_Proposal-Affidavit.pdf)
Y	With Proposal	D	MBE Forms D-1A (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/05/AttachmentDMBE-Forms-1.pdf) **IMPORTANT:** If this RFP contains different Functional Areas or Service Categories. A separate Attachment D-1A is to be submitted for each Functional Area or Service Category where there is a MBE goal.
Y	10 Business Days after recommended award	D	MBE Forms D-1B, D-1C,D-2, D-3A, D-3B (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/05/AttachmentDMBE-Forms-1.pdf)

Applies?	When to Submit	Label	Attachment Name
			Important: Attachment D-1C, if a waiver has been requested, is also required within 10 days of recommended award.
Y	As directed in forms	D	MBE Forms D-4A, D-4B, D-5 (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/05/AttachmentDMBE-Forms-1.pdf)
Y	With Proposal	E	Veteran-Owned Small Business Enterprise (VSBE) Form E-1A (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentE-VSBEForms.pdf) **IMPORTANT:** If this RFP contains different Functional Areas or Service Categories. A separate Attachment E-1A is to be submitted for each Functional Area or Service Category where there is a VSBE goal.
Y	5 Business Days after recommended award	E	VSBE Forms E-1B, E-2, E-3 (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentE-VSBEForms.pdf) **Important:** Attachment E-1B, if a waiver has been requested, is also required within 10 days of recommended award.
Y	With Proposal	F	Maryland Living Wage Requirements for Service Contracts and Affidavit of Agreement (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentF-LivingWageAffidavit.pdf)
Y	With Proposal	G	Federal Funds Attachments (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentG-FederalFundsAttachment.pdf)
Y	With Proposal	H	Conflict of Interest Affidavit and Disclosure (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/05/AttachmentH-Conflict-of-InterestAffidavit.pdf)

Y	5 Business Days after recommended award – However, suggested with Proposal	I	Non-Disclosure Agreement (Contractor) (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-I-Non-DisclosureAgreementContractor.pdf)
Y	5 Business Days after recommended award – However, suggested with Proposal	J	HIPAA Business Associate Agreement (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-J-HIPAABusinessAssociateAgreement.pdf)
N	With Proposal	K	Mercury Affidavit
Y	With Proposal	L	Location of the Performance of Services Disclosure (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-L-PerformanceofServicesDisclosure.pdf)
Y	5 Business Days after recommended award	M	Sample Contract (included in this RFP)
Y	5 Business Days after recommended award	N	Contract Affidavit (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-N-ContractAffidavit.pdf)
Y	With proposal	O	DHS Hiring Agreement (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-O-DHSHiringAgreement.pdf)
Y	With proposal	P	PreService Denial Report Instructions
Y	With proposal	Q	PreService Denial Report Template

Appendices

Applies?	When to Submit	Label	Attachment Name
Y	n/a	1	Abbreviations and Definitions (included in this RFP)
Y	With Proposal	2	Offeror Information Sheet (see link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Appendix2-Bidder_OfferorInformationSheet.pdf)
Y	With Proposal	3	EQRO Resources
Y	With Proposal	4	EPSDT/Healthy Kids Review Standards for CY 2019
Y	With Proposal	5	Systems Performance Review Standards for CY 2019

Y	With Proposal	6	Consumer Report Card
Additional Submissions			
Applies?	**When to Submit**	**Label**	**Document Name**
Y	5 Business Days after recommended award		Evidence of meeting insurance requirements (see **Section 3.6**); 1 copy
Y	10 Business Days after recommended award		PEP; 1 copy

Attachment A. Pre-Proposal Conference Response Form

Solicitation Number MDH OPASS #21-18957

External Quality Review of the Maryland HealthChoice Program

A Pre-Proposal conference will be held on June 8,2021 at teleconference (Refer to Key Summary Sheet)

Please return this form by June 7,2021 advising whether or not your firm plans to attend. The completed form should be returned via e-mail to the Procurement Coordinator at the contact information below:

Procurement Coordinator : Charlise Y. Jefferson
E-mail: charlise.jefferson@maryland.gov

Please indicate:

_____ Yes, the following representatives will be in attendance.

Attendees (Check the RFP for limits to the number of attendees allowed):

1.
2.
3.

_____ No, we will not be in attendance.

Please specify whether any reasonable accommodations are requested (see RFP § 4.1"Pre-Proposal conference"):

Offeror: _____
Offeror Name (please print or type)

By: _____
Signature/Seal

Printed Name: _____
Printed Name

Title: _____
Title

Date: _____
Date

Attachment B. Financial Proposal Instructions & Form

B-1 Financial Proposal Instructions

See separate Excel Financial Proposal Form labeled EQRO Financial Proposal Attachment B.xls.

Attachment C. Proposal Affidavit

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentC-Bid_Proposal-Affidavit.pdf.

Attachment D. Minority Business Enterprise (MBE) Forms

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/05/AttachmentDMBE-Forms-1.pdf.

This solicitation includes a Minority Business Enterprise (MBE) participation goal of ____ percent and all of the following subgoals:

___ percent for African American-owned MBE firms;

_____ percent for Hispanic American-owned MBE firms;

_____ percent for Asian American-owned MBE firms;

__percent for Women-owned MBE firms.

Attachment E. Veteran-Owned Small Business Enterprise (VSBE) Forms

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentE-VSBEForms.pdf.

This solicitation includes a VSBE participation goal of ____%.

Attachment F. Maryland Living Wage Affidavit of Agreement for Service Contracts

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentF-LivingWageAffidavit.pdf to complete the Affidavit.

A. This contract is subject to the Living Wage requirements under Md. Code Ann., State Finance and Procurement Article, Title 18, and the regulations proposed by the Commissioner of Labor and Industry (Commissioner). The Living Wage generally applies to a Contractor or subcontractor who performs work on a State contract for services that is valued at $100,000 or more. An employee is subject to the Living Wage if he/she is at least 18 years old or will turn 18 during the duration of the contract; works at least 13 consecutive weeks on the State Contract and spends at least one-half of the employee's time during any work week on the State Contract.

B. The Living Wage Law does not apply to:

(1) A Contractor who:

(a) Has a State contract for services valued at less than $100,000, or

(b) Employs 10 or fewer employees and has a State contract for services valued at less than $500,000.

(2) A subcontractor who:

(a) Performs work on a State contract for services valued at less than $100,000,

(b) Employs 10 or fewer employees and performs work on a State contract for services valued at less than $500,000, or

(c) Performs work for a Contractor not covered by the Living Wage Law as defined in B(1)(b) above, or B (3) or C below.

(3) Service contracts for the following:

(a) Services with a Public Service Company;

(b) Services with a nonprofit organization;

(c) Services with an officer or other entity that is in the Executive Branch of the State government and is authorized by law to enter into a procurement ("Unit"); or

(d) Services between a Unit and a County or Baltimore City.

C. If the Unit responsible for the State contract for services determines that application of the Living Wage would conflict with any applicable Federal program, the Living Wage does not apply to the contract or program.

D. A Contractor must not split or subdivide a State contract for services, pay an employee through a third party, or treat an employee as an independent Contractor or assign work to employees to avoid the imposition of any of the requirements of Md. Code Ann., State Finance and Procurement Article, Title 18.

E. Each Contractor/subcontractor, subject to the Living Wage Law, will post in a prominent and easily accessible place at the work site(s) of covered employees a notice of the Living Wage Rates, employee rights under the law, and the name, address, and telephone number of the Commissioner.

F. The Commissioner will adjust the wage rates by the annual average increase or decrease, if any, in the Consumer Price Index for all urban consumers for the Washington/Baltimore metropolitan area, or any successor index, for the previous calendar year, not later than 90 days after the start of each fiscal year. The Commissioner will publish any adjustments to the wage rates on the Division of Labor and Industry's website. An employer subject to the Living Wage Law must comply with the rate requirements during the initial term of the contract and all subsequent renewal periods, including any increases in the wage rate, required by the Commissioner, automatically upon the effective date of the revised wage rate.

G. A Contractor/subcontractor who reduces the wages paid to an employee based on the employer's share of the health insurance premium, as provided in Md. Code Ann., State Finance and Procurement Article, §18-103(c), will not lower an employee's wage rate below the minimum wage as set in Md. Code Ann., Labor and Employment Article, §3-413. A Contractor/subcontractor who reduces the wages paid to an employee based on the employer's share of health insurance premium will comply with any record reporting requirements established by the Commissioner.

H. A Contractor/subcontractor may reduce the wage rates paid under Md. Code Ann., State Finance and Procurement Article, §18-103(a), by no more than 50 cents of the hourly cost of the employer's contribution to an employee's deferred compensation plan. A Contractor/subcontractor who reduces the wages paid to an employee based on the employer's contribution to an employee's deferred compensation plan will not lower the employee's wage rate below the minimum wage as set in Md. Code Ann., Labor and Employment Article, §3-413.

I. Under Md. Code Ann., State Finance and Procurement Article, Title 18, if the Commissioner determines that the Contractor/subcontractor violated a provision of this title or regulations of the Commissioner, the Contractor/subcontractor will pay restitution to each affected employee, and the State may assess liquidated damages of $20 per day for each employee paid less than the Living Wage.

J. Information pertaining to reporting obligations may be found by going to the Division of Labor and Industry website http://www.dllr.state.md.us/labor/prev/livingwage.shmtl and clicking on Living Wage for State Service Contracts.

Attachment G. Federal Funds Attachments

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentG-FederalFundsAttachment.pdf.

Attachment H. Conflict of Interest Affidavit and Disclosure

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/AttachmentH-ConflictofInterestAffidavit.pdf.

Attachment I. Non-Disclosure Agreement (Contractor)

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-I-Non-DisclosureAgreementContractor.pdf.

Attachment J. HIPAA Business Associate Agreement

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-J-HIPAABusinessAssociateAgreement.pdf.

Attachment K. Mercury Affidavit

This solicitation does not include the procurement of products known to likely include mercury as a component.

Attachment L. Location of the Performance of Services Disclosure

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-L-PerformanceofServicesDisclosure.pdf.

Attachment M. Contract

Maryland Department of Health (MDH)

"External Quality Review of the Maryland HealthChoice Program"

MDH OPASS #21-18957

THIS CONTRACT (the "Contract") is made this ____ day of _____, 20__ by and between _____ (the "Contractor") and the STATE OF MARYLAND, acting through the MARYLAND Maryland Department of Health ("MDH" or the "Department").

In consideration of the promises and the covenants herein contained, the adequacy and sufficiency of which are hereby acknowledged by the parties, the parties agree as follows:

1. Definitions

In this Contract, the following words have the meanings indicated:

1.1 "COMAR" means Code of Maryland Regulations.

1.2 "Contractor" means the entity first named above whose principal business address is (Contractor's primary address) and whose principal office in Maryland is (Contractor's local address), whose Federal Employer Identification Number or Social Security Number is (Contractor's FEIN), and whose eMaryland Marketplace Advantage vendor ID number is (eMMA Number).

1.3 "Financial Proposal" means the Contractor's [pick one: Financial Proposal or Best and Final Offer (BAFO)] dated _____(Financial Proposal date or BAFO date).

1.4 Minority Business Enterprise (MBE) – Any legal entity certified as defined at COMAR 21.01.02.01B (54) which is certified by the Maryland Department of Transportation under COMAR 21.11.03.

1.5 "RFP" means the Request for Proposals for External Quality Review of the Maryland HealthChoice Program, Solicitation # MDH OPASS #21-18957, and any amendments, addenda, and attachments thereto issued in writing by the State.

1.6 "State" means the State of Maryland.

1.7 "Technical Proposal" means the Contractor's Technical Proposal dated. _____ (Technical Proposal date), as modified and supplemented by the Contractor's responses to requests clarifications and requests for cure, and by any Best and Final Offer.

1.8 "Veteran-owned Small Business Enterprise" (VSBE) means A business that is verified by the Center for Verification and Evaluation (CVE) of the United States Department of Veterans Affairs as a veteran-owned small business. See Code of Maryland Regulations (COMAR) 21.11.13.

1.9 Capitalized terms not defined herein will be ascribed the meaning given to them in the RFP.

2. Scope of Contract

2.1 The Contractor shall perform in accordance with this Contract and Exhibits A-D, which are listed below and incorporated herein by reference. If there is any conflict between this Contract and the Exhibits, the terms of the Contract will control. If there is any conflict among the Exhibits, the following order of precedence will determine the prevailing provision:

Exhibit A – The RFP

Exhibit B – The Contract Affidavit, executed by the Contractor and dated (date of Attachment N)

Exhibit C – The Technical Proposal

Exhibit D – The Financial Proposal

2.2 The Procurement Officer may, at any time, by written order, make unilateral changes in the work within the general scope of the Contract. No other order, statement, or conduct of the Procurement Officer or any other person will be treated as a change or entitle the Contractor to an equitable adjustment under this section. Except as otherwise provided in this Contract, if any change under this section causes an increase or decrease in the Contractor's cost of, or the time required for, the performance of any part of the work, whether or not changed by the order, an equitable adjustment in the Contract price will be made and the Contract modified in writing accordingly. The Contractor must assert in writing its right to an adjustment under this section within thirty (30) days of receipt of written change order and will include a written statement setting forth the nature and cost of such claim. No claim by the Contractor will be allowed if asserted after final payment under this Contract. Failure to agree to an adjustment under this section will be a dispute under the Disputes clause. Nothing in this section will excuse the Contractor from proceeding with the Contract as changed.

2.3 Without limiting the rights of the Procurement Officer under Section 2.2 above, the Contract may be modified by mutual agreement of the parties, provided: (a) the modification is made in writing; (b) all parties sign the modification; and (c) all approvals by the required agencies as described in COMAR Title 21, are obtained.

3. Period of Performance

3.1 The term of this Contract begins on the date the Contract is signed by the Department following any required prior approvals, including approval by the Board of Public Works, if such approval is required (the "Effective Date") and will continue until 5 years ("Initial Term").

3.2 The Contractor's performance under the Contract will commence as of the date provided in a written NTP.

3.3 The Contractor's obligation to pay invoices to subcontractors providing products/services in connection with this Contract, as well as the audit; confidentiality; document retention; patents, copyrights & intellectual property; warranty; indemnification obligations; and limitations of liability under this Contract; and any other obligations specifically identified, will survive expiration or termination of the Contract.

4. Consideration and Payment

4.1 In consideration of the satisfactory performance of the work set forth in this Contract, the Department shall pay the Contractor in accordance with the terms of this Contract and at the prices quoted in the Financial Proposal. Unless properly modified (see above Section 2), payment to the Contractor pursuant to this Contract, including the Initial Term and any Renewal Term, will not exceed the Contracted amount.

4.2 Unless a payment is unauthorized, deferred, delayed, or set-off under COMAR 21.02.07, payments to the Contractor pursuant to this Contract will be made no later than 30 days after the Department's receipt of a proper invoice from the Contractor as required by RFP section 3.3.

The Contractor may be eligible to receive late payment interest at the rate of 9% per annum if:

(1) The Contractor submits an invoice for the late payment interest within thirty days after the date of the State's payment of the amount on which the interest accrued; and

(2) A contract claim has not been filed under State Finance and Procurement Article, Title 15, Subtitle 2, Annotated Code of Maryland.

The State is not liable for interest:

(1) Accruing more than one year after the 31st day after the agency receives the proper invoice; or

(2) On any amount representing unpaid interest. Charges for late payment of invoices are authorized only as prescribed by Title 15, Subtitle 1, of the State Finance and Procurement Article, Annotated Code of Maryland, or by the Public Service Commission of Maryland with respect to regulated public utilities, as applicable.

Final payment under this Contract will not be made until after certification is received from the Comptroller of the State that all taxes have been paid.

Electronic funds transfer will be used by the State to pay Contractor pursuant to this Contract and any other State payments due Contractor unless the State Comptroller's Office grants Contractor an exemption.

4.3 In addition to any other available remedies, if, in the opinion of the Procurement Officer, the Contractor fails to perform in a satisfactory and timely manner, the Procurement Officer may refuse or limit approval of any invoice for payment, and may cause payments to the Contractor to be reduced or withheld until such time as the Contractor meets performance standards as established by the Procurement Officer.

4.4 Payment of an invoice by the Department is not evidence that services were rendered as required under this Contract.

5. Rights to Records

5.1 The Contractor agrees that all documents and materials including, but not limited to, software, reports, drawings, studies, specifications, estimates, tests, maps, photographs, designs, graphics, mechanical, artwork, computations, and data prepared by the Contractor for purposes of this Contract will be the sole property of the State and will be available to the State at any time. The State will have the right to use the same without restriction and without compensation to the Contractor other than that specifically provided by this Contract.

5.2 The Contractor agrees that at all times during the term of this Contract and thereafter, works created as a Deliverable under this Contract (as defined in **Section 7.2**), and services performed under this Contract will be "works made for hire" as that term is interpreted under U.S. copyright law. To the extent that any products created as a Deliverable under this Contract are not works made for hire for the State, the Contractor hereby relinquishes, transfers, and assigns to the State all of its rights, title, and interest (including all intellectual property rights) to all such products created under this Contract, and will cooperate reasonably with the State in effectuating and registering any necessary assignments.

5.3 The Contractor shall report to the Contract Monitor, promptly and in written detail, each notice or claim of copyright infringement received by the Contractor with respect to all data delivered under this Contract.

5.4 The Contractor shall not affix any restrictive markings upon any data, documentation, or other materials provided to the State hereunder and if such markings are affixed, the State will have the right at any time to modify, remove, obliterate, or ignore such warnings.

5.5 Upon termination or expiration of the Contract, the Contractor, at its own expense, will deliver any equipment, software or other property provided by the State to the place designated by the Procurement Officer.

6. Exclusive Use

6.1 The State shall have the exclusive right to use, duplicate, and disclose any data, information, documents, records, or results, in whole or in part, in any manner for any purpose whatsoever, that may be created or generated by the Contractor in connection with this Contract. If any material, including software, is capable of being copyrighted, the State will be the copyright owner and Contractor may copyright material connected with this project only with the express written approval of the State.

6.2 Except as may otherwise be set forth in this Contract, Contractor will not use, sell, sub-lease, assign, give, or otherwise transfer to any third party any other information or material provided to Contractor by the Department or developed by Contractor relating to the Contract, except as provided for in **Section 8**. **Confidential or Proprietary Information and Documentation**.

7. Patents, Copyrights, and Intellectual Property

7.1. All copyrights, patents, trademarks, trade secrets, and any other intellectual property rights existing prior to the Effective Date of this Contract will belong to the party that owned such rights immediately prior to the Effective Date ("Pre-Existing Intellectual Property"). If any design, device, material, process, or other item provided by Contractor is covered by a patent or copyright or which is proprietary to or a trade secret of another, the Contractor will obtain the necessary permission or license to permit the State to use such item or items pursuant to its rights granted under the Contract.

7.2 Except for (1) information created or otherwise owned by the Department or licensed by the Department from third parties, including all information provided by the Department to Contractor; (2) materials created by Contractor or its subcontractor(s) specifically for the State under the Contract ("Deliverables"), except for any Contractor Pre-Existing Intellectual Property included therein; and (3) the license rights granted to the State, all right, title, and interest in the intellectual property embodied in the solution, including the know-how and methods by which the solution is provided and the processes that make up the solution, will belong solely and exclusively to Contractor and its licensors, and the Department will have no rights to the same except as expressly granted in this Contract. Any SaaS Software developed by Contractor during the performance of the Contract will belong solely and exclusively to Contractor and its licensors. For all Software provided by the Contractor under the Contract, Contractor hereby grants to the State a nonexclusive, irrevocable, unlimited, perpetual, non-cancelable, and non-terminable right to use and make copies of the Software and any modifications to the Software. For all Contractor Pre-Existing Intellectual Property embedded in any Deliverables, Contractor grants to the State a license to use such Contractor Pre-Existing Intellectual Property in connection with its permitted use of such Deliverable. During the period between delivery of a Deliverable by Contractor and the date of payment therefor by the State in accordance with this Contract (including throughout the duration of any payment dispute discussions), subject to the terms and conditions contained herein, Contractor grants the State a royalty-free, non-exclusive, limited license to use such Deliverable and to use any Contractor Materials contained therein in accordance with this Contract.

7.3. Subject to the terms of **Section 10**, Contractor will defend, indemnify and hold harmless the State and its agents and employees, from and against any and all claims, costs, losses, damages, liabilities, judgments and expenses (including without limitation reasonable attorneys' fees) arising out of or in connection with any third party claim that the Contractor-provided products/services infringe, misappropriate or otherwise violate any third party intellectual property rights. Contractor will not enter into any settlement involving third party claims that contains any admission of or stipulation

to any guilt, fault, liability or wrongdoing by the State or that adversely affects the State's rights or interests, without the State's prior written consent.

7.4 Without limiting Contractor's obligations under Section 5.3, if an infringement claim occurs, or if the State or the Contractor believes such a claim is likely to occur, Contractor (after consultation with the State and at no cost to the State): (a) will procure for the State the right to continue using the allegedly infringing component or service in accordance with its rights under this Contract; or (b) replace or modify the allegedly infringing component or service so that it becomes non-infringing and remains compliant with all applicable specifications.

7.5 Except as otherwise provided herein, Contractor will not acquire any right, title or interest (including any intellectual property rights subsisting therein) in or to any goods, Software, technical information, specifications, drawings, records, documentation, data or any other materials (including any derivative works thereof) provided by the State to the Contractor. Notwithstanding anything to the contrary herein, the State may, in its sole and absolute discretion, grant the Contractor a license to such materials, subject to the terms of a separate writing executed by the Contractor and an authorized representative of the State as well as all required State approvals.

7.6 Without limiting the generality of the foregoing, neither Contractor nor any of its subcontractors will use any Software or technology in a manner that will cause any patents, copyrights or other intellectual property which are owned or controlled by the State or any of its affiliates (or for which the State or any of its subcontractors has received license rights) to become subject to any encumbrance or terms and conditions of any third party or open source license (including, without limitation, any open source license listed on http://www.opensource.org/licenses/alphabetical) (each an "Open Source License"). These restrictions, limitations, exclusions and conditions will apply even if the State or any of its subcontractors becomes aware of or fails to act in a manner to address any violation or failure to comply therewith. No act by the State or any of its subcontractors that is undertaken under this Contract as to any Software or technology will be construed as intending to cause any patents, copyrights or other intellectual property that are owned or controlled by the State (or for which the State has received license rights) to become subject to any encumbrance or terms and conditions of any open source license.

7.7 The Contractor will report to the Department, promptly and in written detail, each notice or claim of copyright infringement received by the Contractor with respect to all Deliverables delivered under this Contract.

7.8 The Contractor will not affix (or permit any third party to affix), without the Department's consent, any restrictive markings upon any Deliverables that are owned by the State, and if such markings are affixed, the Department will have the right at any time to modify, remove, obliterate, or ignore such warnings.

8. Confidential or Proprietary Information and Documentation

8.1 Subject to the Maryland Public Information Act and any other applicable laws including, without limitation, HIPAA, the HI-TECH Act, and the Maryland Medical Records Act and regulations promulgated pursuant thereto, all confidential or proprietary information and documentation relating to either party (including without limitation, any information or data stored within the Contractor's computer systems or cloud infrastructure, if applicable) will be held in confidence by the other party. Each party will, however, be permitted to disclose, as provided by and consistent with applicable law, relevant confidential information to its officers, agents, and Contractor Personnel to the extent that such disclosure is necessary for the performance of their duties under this Contract. Each officer, agent, and Contractor Personnel to whom any of the State's confidential information is to be disclosed will be advised by Contractor provided that each officer, agent, and Contractor Personnel to whom any of the State's confidential information is to be disclosed will be

advised by Contractor of the obligations hereunder, and bound by, confidentiality at least as restrictive as those of set forth in this Contract..

8.2 The provisions of this section will not apply to information that: (a) is lawfully in the public domain; (b) has been independently developed by the other party without violation of this Contract; (c) was already rightfully in the possession of such party; (d) was supplied to such party by a third party lawfully in possession thereof and legally permitted to further disclose the information; or (e) which such party is required to disclose by law.

9. Loss of Data

9.1 In the event of loss of any State data or records where such loss is due to the act or omission of the Contractor or any of its subcontractors or agents, the Contractor will be responsible for restoring or recreating, as applicable, such lost data in the manner and on the schedule set by the Contract Monitor. The Contractor will ensure that all data is backed up and recoverable by the Contractor. At no time will any Contractor actions (or any failures to act when Contractor has a duty to act) damage or create any vulnerabilities in data bases, systems, platforms, and applications with which the Contractor is working hereunder.

9.2 In accordance with prevailing federal or state law or regulations, the Contractor will report the loss of non-public data as directed in **RFP Section 3.7**.

9.3 Protection of data and personal privacy (as further described and defined in RFP Section 3.8) will be an integral part of the business activities of the Contractor to ensure there is no inappropriate or unauthorized use of State information at any time. To this end, the Contractor will safeguard the confidentiality, integrity and availability of State information and comply with the conditions identified in **RFP Section 3.7**.

10. Indemnification and Notification of Legal Requests

10.1. At its sole cost and expense, Contractor will (i) indemnify and hold the State, its employees and agents harmless from and against any and all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs and expenses (including but not limited to attorneys' fees and costs), whether or not involving a third party claim, which arise out of or relate to the Contractor's, or any of its subcontractors', performance of this Contract and (ii) cooperate, assist, and consult with the State in the defense or investigation of any such claim, demand, action or suit. Contractor will not enter into any settlement involving third party claims that contains any admission of or stipulation to any guilt, fault, liability or wrongdoing by the State or that adversely affects the State's rights or interests, without the State's prior written consent.

10.2. The State has no obligation: (i) to provide legal counsel or defense to the Contractor or its subcontractors in the event that a suit, claim or action of any character is brought against the Contractor or its subcontractors as a result of or relating to the Contractor's obligations or performance under this Contract, or (ii) to pay any judgment or settlement of any such suit, claim or action. Notwithstanding the foregoing, the Contractor will promptly notify the Procurement Officer of any such claims, demands, actions, or suits.

10.3. Notification of Legal Requests. In the event the Contractor receives a subpoena or other validly issued administrative or judicial process, or any discovery request in connection with any litigation, requesting State Pre-Existing Intellectual Property, of other information considered to be the property of the State, including but not limited to State data stored with or otherwise accessible by the Contractor, the Contractor will not respond to such subpoena, process or other legal request without first notifying the State, unless prohibited by law from providing such notice The Contractor will promptly notify the State of such receipt providing the State with a reasonable

opportunity to intervene in the proceeding before the time that Contractor is required to comply with such subpoena, other process or discovery request. .

11. Non-Hiring of Employees

No official or employee of the State, as defined under Md. Code Ann., General Provisions Article, § 5-101, whose duties as such official or employee include matters relating to or affecting the subject matter of this Contract, will, during the pendency and term of this Contract and while serving as an official or employee of the State, become or be an employee of the Contractor or any entity that is a subcontractor on this Contract.

12. Disputes

This Contract will be subject to the provisions of Md. Code Ann., State Finance and Procurement Article, Title 15, Subtitle 2, and COMAR 21.10 (Administrative and Civil Remedies). Pending resolution of a claim, the Contractor will proceed diligently with the performance of the Contract in accordance with the Procurement Officer's decision. Unless a lesser period is provided by applicable statute, regulation, or the Contract, the Contractor must file a written notice of claim with the Procurement Officer within thirty (30) days after the basis for the claim is known or should have been known, whichever is earlier. Contemporaneously with or within thirty (30) days of the filing of a notice of claim, but no later than the date of final payment under the Contract, the Contractor must submit to the Procurement Officer its written claim containing the information specified in COMAR 21.10.04.02.

13. Maryland Law Prevails

13.1 This Contract will be construed, interpreted, and enforced according to the laws of the State of Maryland.

13.2 The Maryland Uniform Computer Information Transactions Act (Commercial Law Article, Title 22 of the Annotated Code of Maryland) does not apply to this Contract or any purchase order, task order, or Notice to Proceed issued thereunder, or any software, or any software license acquired hereunder.

13.3 Any and all references to the Maryland Code, annotated and contained in this Contract will be construed to refer to such Code sections as are from time to time amended.

14. Nondiscrimination in Employment

The Contractor agrees: (a) not to discriminate in any manner against an employee or applicant for employment because of race, color, religion, creed, age, sex, sexual orientation, gender identification, marital status, national origin, ancestry, genetic information, or any otherwise unlawful use of characteristics, or disability of a qualified individual with a disability unrelated in nature and extent so as to reasonably preclude the performance of the employment, or the individual's refusal to submit to a genetic test or make available the results of a genetic test; (b) to include a provision similar to that contained in subsection (a), above, in any underlying subcontract except a subcontract for standard commercial supplies or raw materials; and (c) to post and to cause subcontractors to post in conspicuous places available to employees and applicants for employment, notices setting forth the substance of this clause.

15. Contingent Fee Prohibition

The Contractor warrants that it has not employed or retained any person, partnership, corporation, or other entity, other than a bona fide employee or agent working for the Contractor to solicit or secure the Contract, and that the Contractor has not paid or agreed to pay any person, partnership, corporation, or other entity, other than a bona fide employee or agent, any fee or any other consideration contingent on the making of this Contract.

16. Non-Availability of Funding

If the General Assembly fails to appropriate funds or if funds are not otherwise made available for continued performance for any fiscal period of this Contract succeeding the first fiscal period, this Contract will be canceled automatically as of the beginning of the fiscal year for which funds were not appropriated or otherwise made available; provided, however, that this will not affect either the State's or the Contractor's rights under any termination clause in this Contract. The effect of termination of the Contract hereunder will be to discharge both the Contractor and the State from future performance of the Contract, but not from their rights and obligations existing at the time of termination. The Contractor will be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the Contract. The State will notify the Contractor as soon as it has knowledge that funds may not be available for the continuation of this Contract for each succeeding fiscal period beyond the first.

17. Termination for Default

If the Contractor fails to fulfill its obligations under this Contract properly and on time, or otherwise violates any provision of the Contract, the State may terminate the Contract by written notice to the Contractor. The notice will specify the acts or omissions relied upon as cause for termination. All finished or unfinished work provided by the Contractor will, at the State's option, become the State's property. The State will pay the Contractor fair and equitable compensation for satisfactory performance prior to receipt of notice of termination, less the amount of damages caused by the Contractor's breach. If the damages are more than the compensation payable to the Contractor, the Contractor will remain liable after termination and the State can affirmatively collect damages. Termination hereunder, including the termination of the rights and obligations of the parties, will be governed by the provisions of COMAR 21.07.01.11B.

18. Termination for Convenience

The performance of work under this Contract may be terminated by the State in accordance with this clause in whole, or from time to time in part, whenever the State will determine that such termination is in the best interest of the State. The State will pay all reasonable costs associated with this Contract that the Contractor has incurred up to the date of termination, and all reasonable costs associated with termination of the Contract. However, the Contractor will not be reimbursed for any anticipatory profits that have not been earned up to the date of termination. Termination hereunder, including the determination of the rights and obligations of the parties, will be governed by the provisions of COMAR 21.07.01.12A (2).

19. Delays and Extensions of Time

19.1 The Contractor agrees to prosecute the work continuously and diligently and no charges or claims for damages will be made by it for any delays or hindrances from any cause whatsoever during the progress of any portion of the work specified in this Contract.

19.2 Time extensions will be granted only for excusable delays that arise from unforeseeable causes beyond the control and without the fault or negligence of the Contractor, including but not restricted to, acts of God, acts of the public enemy, acts of the State in either its sovereign or contractual capacity, acts of another Contractor in the performance of a contract with the State, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, or delays of subcontractors or suppliers arising from unforeseeable causes beyond the control and without the fault or negligence of either the Contractor or the subcontractors or suppliers.

20. Suspension of Work

The State unilaterally may order the Contractor in writing to suspend, delay, or interrupt all or any part of its performance for such period of time as the Procurement Officer may determine to be appropriate for the convenience of the State.

21. Pre-Existing Regulations

In accordance with the provisions of Section 11-206 of the State Finance and Procurement Article, Annotated Code of Maryland, the regulations set forth in Title 21 of the Code of Maryland Regulations (COMAR 21) in effect on the date of execution of this Contract are applicable to this Contract.

22. Financial Disclosure

The Contractor will comply with the provisions of Section13-221 of the State Finance and Procurement Article of the Annotated Code of Maryland, which requires that every business that enters into contracts, leases, or other agreements with the State or its agencies during a calendar year under which the business is to receive in the aggregate, $100,000 or more, will within 30 days of the time when the aggregate value of these contracts, leases or other agreements reaches $100,000, file with the Secretary of State of Maryland certain specified information to include disclosure of beneficial ownership of the business.

23. Political Contribution Disclosure

The Contractor will comply with Election Law Article, Title 14, Annotated Code of Maryland, which requires that every person that enters into a procurement contract with the State, a county, or a municipal corporation, or other political subdivision of the State, during a calendar year in which the person receives a contract with a governmental entity in the amount of $200,000 or more, will file with the State Board of Elections statements disclosing: (a) any contributions made during the reporting period to a candidate for elective office in any primary or general election; and (b) the name of each candidate to whom one or more contributions in a cumulative amount of $500 or more were made during the reporting period. The statement will be filed with the State Board of Elections: (a) before execution of a contract by the State, a county, a municipal corporation, or other political subdivision of the State, and will cover the 24 months prior to when a contract was awarded; and (b) if the contribution is made after the execution of a contract, then twice a year, throughout the contract term, on or before: (i) May 31, to cover the six (6) month period ending April 30; and (ii) November 30, to cover the six (6) month period ending October 31. Additional information is available on the State Board of Elections website: http://www.elections.state.md.us/campaign_finance/index.html.

24. Retention of Records

The Contractor and subcontractors will retain and maintain all records and documents in any way relating to this Contract for (i) three (3) years after final payment by the State hereunder, or (ii) any applicable federal or State retention requirements (such as HIPAA) or condition of award, , whichever is longer, and will make them available for inspection and audit by authorized representatives of the State, as designated by the Procurement Officer, at all reasonable times. The Contractor will provide copies of all documents requested by the State, including, but not limited to itemized billing documentation containing the dates, hours spent and work performed by the Contractor and its subcontractors under the Contract. All records related in any way to the Contract are to be retained for the entire time provided under this section.

25. Right to Audit

25.1 The State reserves the right, at its sole discretion and at any time, to perform an audit of the Contractor's performance under this Contract. An audit is defined as a planned and documented

independent activity performed by qualified personnel, including but not limited to State and federal auditors, to determine by investigation, examination, or evaluation of objective evidence from data, statements, records, operations and performance practices (financial or otherwise) the Contractor's compliance with the Contract, including but not limited to adequacy and compliance with established procedures and internal controls over the services performed pursuant to the Contract.

25.2 Upon three (3) Business Days' notice, the State will be provided reasonable access to Contractor's records to perform any such audits. The Department may conduct these audits with any or all of its own internal resources or by securing the services of a third party accounting or audit firm, solely at the Department's election. The Department may copy any record related to the services performed pursuant to the Contract. The Contractor agrees to fully cooperate and assist in any audit conducted by or on behalf of the State, including, by way of example only, making records and employees available as, where, and to the extent requested by the State and by assisting the auditors in reconciling any audit variances. Contractor will not be compensated for providing any such cooperation and assistance.

25.3 The right to audit will include any of the Contractor's subcontractors including but not limited to any lower tier subcontractor(s). The Contractor will ensure the Department has the right to audit such subcontractor(s).

26. Compliance with Laws

The Contractor hereby represents and warrants that:

a. It is qualified to do business in the State and that it will take such action as, from time to time hereafter, may be necessary to remain so qualified;

b. It is not in arrears with respect to the payment of any monies due and owing the State, or any department or unit thereof, including but not limited to the payment of taxes and employee benefits, and that it will not become so in arrears during the Term;

c. It will comply with all federal, State and local laws, regulations, and ordinances applicable to its activities and obligations under this Contract; and

d. It will obtain, at its expense, all licenses, permits, insurance, and governmental approvals, if any, necessary to the performance of its obligations under this Contract.

27. Cost and Price Certification

27.1 The Contractor, by submitting cost or price information certifies that, to the best of its knowledge, the information submitted is accurate, complete, and current as of the date of its Proposal.

27.2 The price under this Contract and any change order or modification hereunder, including profit or fee, will be adjusted to exclude any significant price increases occurring because the Contractor furnished cost or price information which, as of the date of its Proposal, was inaccurate, incomplete, or not current.

28. Subcontracting; Assignment

The Contractor may not subcontract any of its obligations under this Contract without obtaining the prior written approval of the Procurement Officer, nor may the Contractor assign this Contract or any of its rights or obligations hereunder, without the prior written approval of the Procurement Officer, each at the State's sole and absolute discretion; provided, however, that a Contractor may assign monies receivable under a contract after written notice to the State. Any subcontracts will include such language as may be required in various clauses contained within this Contract, exhibits, and attachments. The Contract will not be assigned until all approvals, documents, and affidavits are

completed and properly registered. The State will not be responsible for fulfillment of the Contractor's obligations to its subcontractors.

29. Limitations of Liability

29.1 Contractor will be liable for any loss or damage to the State occasioned by the acts or omissions of Contractor, its subcontractors, agents or employees as follows:

(a) For infringement of patents, trademarks, trade secrets and copyrights as provided in **Section 7 "Patents, Copyrights, Intellectual Property"** of this Contract;

(b) Without limitation for damages for bodily injury (including death) and damage to real property and tangible personal property; and

(c) For all other claims, damages, loss, costs, expenses, suits or actions in any way related to this Contract and regardless of the basis on which the claim is made, Contractor's liability will be unlimited.

(d) In no event will the existence of a subcontract operate to release or reduce the liability of Contractor hereunder. For purposes of this Contract, Contractor agrees that all subcontractors will be held to be agents of Contractor.

29.2 Contractor's indemnification obligations for Third party claims arising under Section 6 ("Indemnification") of this Contract are included in this limitation of liability only if the State is immune from liability. Contractor's indemnification liability for third party claims arising under Section 6 of this Contract will be unlimited if the State is not immune from liability for claims arising under Section 6.

29.3. In no event will the existence of a subcontract operate to release or reduce the liability of Contractor hereunder. For purposes of this Contract, Contractor agrees that it is responsible for performance of the services and compliance with the relevant obligations hereunder by its subcontractors.

30. Commercial Nondiscrimination

30.1 As a condition of entering into this Contract, Contractor represents and warrants that it will comply with the State's Commercial Nondiscrimination Policy, as described under Title 19 of the State Finance and Procurement Article of the Annotated Code of Maryland. As part of such compliance, Contractor may not discriminate on the basis of race, color, religion, ancestry, national origin, sex, age, marital status, sexual orientation, sexual identity, genetic information or an individual's refusal to submit to a genetic test or make available the results of a genetic test or on the basis of disability, or otherwise unlawful forms of discrimination in the solicitation, selection, hiring, or commercial treatment of subcontractors, vendors, suppliers, or commercial customers, nor will Contractor retaliate against any person for reporting instances of such discrimination. Contractor will provide equal opportunity for subcontractors, vendors, and suppliers to participate in all of its public sector and private sector subcontracting and supply opportunities, provided that this clause does not prohibit or limit lawful efforts to remedy the effects of marketplace discrimination that have occurred or are occurring in the marketplace. Contractor understands that a material violation of this clause will be considered a material breach of this Contract and may result in termination of this Contract, disqualification of Contractor from participating in State contracts, or other sanctions. This clause is not enforceable by or for the benefit of, and creates no obligation to, any third party.

30.2 As a condition of entering into this Contract, upon the request of the Commission on Civil Rights, and only after the filing of a complaint against Contractor under Title 19 of the State Finance and Procurement Article of the Annotated Code of Maryland, as amended from time to time, Contractor agrees to provide within 60 days after the request a complete list of the names of all subcontractors, vendors, and suppliers that Contractor has used in the past four (4) years on any of its contracts that

were undertaken within the State of Maryland, including the total dollar amount paid by Contractor on each subcontract or supply contract. Contractor further agrees to cooperate in any investigation conducted by the State pursuant to the State Commercial Nondiscrimination Policy as set forth under Title 19 of the State Finance and Procurement Article of the Annotated Code of Maryland, and to provide any documents relevant to any investigation that are requested by the State. Contractor understands that violation of this clause is a material breach of this Contract and may result in Contract termination, disqualification by the State from participating in State contracts, and other sanctions.

30.3 The Contractor will include the language from 30.1, or similar clause approved in writing by the Department, in all subcontracts.

31. Prompt Pay Requirements

31.1 If the Contractor withholds payment of an undisputed amount to its subcontractor, the Department, at its option and in its sole discretion, may take one or more of the following actions:

(a) Not process further payments to the Contractor until payment to the subcontractor is verified;

(b) Suspend all or some of the Contract work without affecting the completion date(s) for the Contract work;

(c) Pay or cause payment of the undisputed amount to the subcontractor from monies otherwise due or that may become due to the Contractor;

(d) Place a payment for an undisputed amount in an interest-bearing escrow account; or

(e) Take other or further actions as appropriate to resolve the withheld payment.

31.2 An "undisputed amount" means an amount owed by the Contractor to a subcontractor for which there is no good faith dispute. Such "undisputed amounts" include, without limitation: (a) retainage which had been withheld and is, by the terms of the agreement between the Contractor and subcontractor, due to be distributed to the subcontractor; and (b) an amount withheld because of issues arising out of an agreement or occurrence unrelated to the agreement under which the amount is withheld.

31.3 An act, failure to act, or decision of a Procurement Officer or a representative of the Department concerning a withheld payment between the Contractor and a subcontractor under this **section 31**, may not:

(a) Affect the rights of the contracting parties under any other provision of law;

(b) Be used as evidence on the merits of a dispute between the Department and the Contractor in any other proceeding; or

(c) Result in liability against or prejudice the rights of the Department.

31.4 The remedies enumerated above are in addition to those provided under COMAR 21.11.03.13 with respect to subcontractors that have contracted pursuant to the MBE program.

31.5 To ensure compliance with certified MBE subcontract participation goals, the Department may, consistent with COMAR 21.11.03.13, take the following measures:

(a) Verify that the certified MBEs listed in the MBE participation schedule actually are performing work and receiving compensation as set forth in the MBE participation schedule. This verification may include, as appropriate:

i. Inspecting any relevant records of the Contractor;

ii. Inspecting the jobsite; and

iii. Interviewing subcontractors and workers.

Verification will include a review of:

i. The Contractor's monthly report listing unpaid invoices over thirty (30) days old from certified MBE subcontractors and the reason for nonpayment; and

ii. The monthly report of each certified MBE subcontractor, which lists payments received from the Contractor in the preceding thirty (30) days and invoices for which the subcontractor has not been paid.

(b) If the Department determines that the Contractor is not in compliance with certified MBE participation goals, then the Department will notify the Contractor in writing of its findings, and will require the Contractor to take appropriate corrective action. Corrective action may include, but is not limited to, requiring the Contractor to compensate the MBE for work performed as set forth in the MBE participation schedule.

(c) If the Department determines that the Contractor is in material noncompliance with MBE Contract provisions and refuses or fails to take the corrective action that the Department requires, then the Department may:

i. Terminate the Contract;

ii. Refer the matter to the Office of the Attorney General for appropriate action; or

iii. Initiate any other specific remedy identified by the Contract, including the contractual remedies required by any applicable laws, regulations, and directives regarding the payment of undisputed amounts.

(d) Upon completion of the Contract, but before final payment or release of retainage or both, the Contractor will submit a final report, in affidavit form under the penalty of perjury, of all payments made to, or withheld from, MBE subcontractors.

32. Living Wage

If a Contractor subject to the Living Wage law fails to submit all records required under COMAR 21.11.10.05 to the Commissioner of Labor and Industry at the Department of Labor, Licensing and Regulation, the Department may withhold payment of any invoice or retainage. The Department may require certification from the Commissioner on a quarterly basis that such records were properly submitted.

33. Use of Estimated Quantities

Unless specifically indicated otherwise in the State's solicitation or other controlling documents related to the Scope of Work, any sample amounts provided are estimates only and the Department does not guarantee a minimum or maximum number of units or usage in the performance of this Contract.

34. Risk of Loss; Transfer of Title

Risk of loss for conforming supplies, equipment, materials and Deliverables furnished to the State hereunder will remain with the Contractor until such supplies, equipment, materials and Deliverables are received and accepted by the State, following which, title will pass to the State.

35. Effect of Contractor Bankruptcy

All rights and licenses granted by the Contractor under this Contract are and will be deemed to be rights and licenses to "intellectual property," and the subject matter of this Contract, including services, is and will be deemed to be "embodiments of intellectual property" for purposes of and as such terms are used and interpreted under § 365(n) of the United States Bankruptcy Code ("Code") (11 U.S.C. § 365(n) (2010)). The State has the right to exercise all rights and elections under the Code and all other applicable bankruptcy, insolvency and similar laws with respect to this Contract (including all executory statement of works). Without limiting the generality of the foregoing, if the Contractor or its estate becomes subject to any bankruptcy or similar proceeding: (a) subject to the State's rights of election, all rights and licenses granted to the State under this Contract will continue subject to the respective terms and conditions of this Contract; and (b) the State will be entitled to a complete duplicate of (or complete access to, as appropriate) all such intellectual property and embodiments of intellectual property, and the same, if not already in the State's possession, will be promptly delivered to the State, unless the Contractor elects to and does in fact continue to perform all of its obligations under this Contract.

36. Miscellaneous

36.1 Any provision of this Contract which contemplates performance or observance subsequent to any termination or expiration of this Contract will survive termination or expiration of this Contract and continue in full force and effect.

36.2 If any term contained in this Contract is held or finally determined to be invalid, illegal, or unenforceable in any respect, in whole or in part, such term will be severed from this Contract, and the remaining terms contained herein will continue in full force and effect, and will in no way be affected, prejudiced, or disturbed thereby.

36.3 The headings of the sections contained in this Contract are for convenience only and will not be deemed to control or affect the meaning or construction of any provision of this Contract.

36.4 This Contract may be executed in any number of counterparts, each of which will be deemed an original, and all of which together will constitute one and the same instrument. Signatures provided by facsimile or other electronic means, e,g, and not by way of limitation, in Adobe .PDF sent by electronic mail, will be deemed to be original signatures.

37. Contract Monitor and Procurement Officer

37.1 The State representative for this Contract who is primarily responsible for Contract administration functions, including issuing written direction, invoice approval, monitoring this Contract to ensure compliance with the terms and conditions of the Contract, monitoring MBE and VSBE compliance, and achieving completion of the Contract on budget, on time, and within scope. The Contract Monitor may authorize in writing one or more State representatives to act on behalf of the Contract Monitor in the performance of the Contract Monitor's responsibilities. The Department may change the Contract Monitor at any time by written notice to the Contractor.

37.2 The Procurement Officer has responsibilities as detailed in the Contract, and is the only State representative who can authorize changes to the Contract. The Department may change the Procurement Officer at any time by written notice to the Contractor.

38. Notices

All notices hereunder will be in writing and either delivered personally or sent by certified or registered mail, postage prepaid, as follows:

If to the State:

Stephanie Boyd

201 W Preston Street

Baltimore, Maryland 21201

Phone Number: 410-767-1740

E-Mail: Stephaniea.boyd@maryland.gov

With a copy to:

Queen Davis

Maryland Department of Health (MDH)

Office of Procurement and Support Services

201 W. Preston Street Room 416B

Baltimore, MD 21201

Phone Number: 410-767-5335

E-Mail: queen.davis@maryland.gov

If to the Contractor:

(Contractor's Name)

(Contractor's primary address)

Attn: _____

Parent Company Guarantor

Contact: _____

Attn: _____

39. Liquidated Damages for MBE

39.1 The Contract requires the Contractor to comply in good faith with the MBE Program and Contract provisions. The State and the Contractor acknowledge and agree that the State will incur damages, including but not limited to loss of goodwill, detrimental impact on economic development, and diversion of internal staff resources, if the Contractor does not comply in good faith with the requirements of the MBE Program and MBE Contract provisions. The parties further acknowledge and agree that the damages the State might reasonably be anticipated to accrue as a result of such lack of compliance are difficult to ascertain with precision.

39.2 Therefore, upon issuance of a written determination by the State that the Contractor failed to comply in good faith with one or more of the specified MBE Program requirements or MBE Contract provisions, the Contractor will pay liquidated damages to the State at the rates set forth below. The Contractor expressly agrees that the State may withhold payment on any invoices as a set-off against liquidated damages owed. The Contractor further agrees that for each specified violation, the agreed upon liquidated damages are reasonably proximate to the loss the State is anticipated to incur as a result of such violation.

(a) Failure to submit each monthly payment report in full compliance with COMAR 21.11.03.13B (3): $33.00 per day until the monthly report is submitted as required.

(b) Failure to include in its agreements with MBE subcontractors a provision requiring submission of payment reports in full compliance with COMAR 21.11.03.13B (4): $84.00 per MBE subcontractor.

(c) Failure to comply with COMAR 21.11.03.12 in terminating, canceling, or changing the scope of work/value of a contract with an MBE subcontractor and amendment of the MBE participation schedule: the difference between the dollar value of the MBE participation commitment on the MBE participation schedule for that specific MBE firm and the dollar value of the work performed by that MBE firm for the Contract.

(d) Failure to meet the Contractor's total MBE participation goal and sub goal commitments: the difference between the dollar value of the total MBE participation commitment on the MBE participation schedule and the MBE participation actually achieved.

(e) Failure to promptly pay all undisputed amounts to an MBE subcontractor in full compliance with the prompt payment provisions of the Contract: $100.00 per day until the undisputed amount due to the MBE subcontractor is paid.

39.2 Notwithstanding the assessment or availability of liquidated damages, the State reserves the right to terminate the Contract and exercise any and all other rights or remedies which may be available under the Contract or Law.

40. Parent Company Guarantee

(Corporate name of Contractor's Parent Company) hereby guarantees absolutely the full, prompt, and complete performance by (Contractor) of all the terms, conditions and obligations contained in this Contract, as it may be amended from time to time, including any and all exhibits that are now or may become incorporated hereunto, and other obligations of every nature and kind that now or may in the future arise out of or in connection with this Contract, including any and all financial commitments, obligations, and liabilities. (Corporate name of Contractor's Parent Company) may not transfer this absolute guaranty to any other person or entity without the prior express written approval of the State, which approval the State may grant, withhold, or qualify in its sole and absolute subjective discretion. (Corporate name of Contractor's Parent Company) further agrees that if the State brings any claim, action, lawsuit or proceeding against (Contractor), (Corporate name of Contractor's Parent Company) may be named as a party, in its capacity as Absolute Guarantor.

41. Federal Department of Health and Human Services (DHHS) Exclusion Requirements

The Contractor agrees that it will comply with federal provisions (pursuant to §§ 1128 and 1156 of the Social Security Act and 42 C.F.R. 1001) that prohibit payments under certain federal health care programs to any individual or entity that is on the List of Excluded Individuals/Entities maintained by DHHS. By executing this Contract, the Contractor affirmatively declares that neither it nor any employee is, to the best of its knowledge, subject to exclusion. The Contractor agrees, further, during the term of this Contract, to check the List of Excluded Individuals/Entities prior to hiring or assigning individuals to work on this Contract, and to notify the Department immediately of any identification of the Contractor or an individual employee as excluded, and of any DHHS action or proposed action to exclude the Contractor or any Contractor employee.

42. Compliance with federal Health Insurance Portability and Accountability Act (HIPAA) and State Confidentiality Law

42.1 The Contractor acknowledges its duty to become familiar with and comply, to the extent applicable, with all requirements of the federal Health Insurance Portability and Accountability Act (HIPAA),

42 U.S.C. § 1320d et seq., and implementing regulations including 45 C.F.R. Parts 160 and 164. The Contractor also agrees to comply with the Maryland Confidentiality of Medical Records Act (MCMRA), Md. Code Ann. Health-General §§ 4-301 et seq. This obligation includes:

(a) As necessary, adhering to the privacy and security requirements for protected health information and medical records under HIPAA and MCMRA and making the transmission of all electronic information compatible with the HIPAA requirements;

(b) Providing training and information to employees regarding confidentiality obligations as to health and financial information and securing acknowledgement of these obligations from employees to be involved in the Contract; and

(c) Otherwise providing good information management practices regarding all health information and medical records.

42.2 Based on the determination by the Department that the functions to be performed in accordance with the scope of work set forth in the solicitation constitute business associate functions as defined in HIPAA, the selected Offeror will execute a business associate agreement as required by HIPAA regulations at 45 C.F.R. 164.504 and in the form as required by the Department.

42.3 "Protected Health Information" as defined in the HIPAA regulations at 45 C.F.R. 160.103 and 164.501, means information transmitted as defined in the regulations, that is individually identifiable; that is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and that is related to the past, present, or future physical or mental health or condition of an individual, to the provision of healthcare to an individual, or to the past, present, or future payment for the provision of healthcare to an individual. The definition excludes certain education records as well as employment records held by a covered entity in its role as employer.

SIGNATURES ON NEXT PAGE

IN WITNESS THEREOF, the parties have executed this Contract as of the date hereinabove set forth.

Contractor	State of Maryland Maryland Department of Health (MDH)
By:	By: <<agencyContractSigner>>, <<agencyContractSignerTitle>>
Date	
PARENT COMPANY (GUARANTOR) (if applicable)	By:
_____	_____
By:	Date
_____	
Date	

Approved for form and legal sufficiency
this ____ day of _____, 20___.

_____
Assistant Attorney General

Contract MDH OPASS #21-18957

APPROVED BY BPW: _____ _____
(Date) (BPW Item #)

Attachment N. Contract Affidavit

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-N-ContractAffidavit.pdf.

Attachment O. DHS Hiring Agreement

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Attachment-O-DHSHiringAgreement.pdf.

Attachment P. PreService Denial Report Instructions

See separate Word document labeled MCO PA_Preservice Denial Quarterly Reporting Form Instructions Rev 2.20.docx

Attachment Q. PreService Denial Report Template

See separate Excel document labeled MCO PA_Preservice Denial Quarterly Reporting Form Rev 12.2019v3 Final.xlsx

Appendix 1. – Abbreviations and Definitions

For purposes of this RFP, the following abbreviations or terms have the meanings indicated below:

A. Acceptable Use Policy (AUP) - A written policy documenting constraints and practices that a user must agree to in order to access a private network or the Internet.

B. Access – The ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any information system resource.

C. Accreditation – A process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined criteria and standards of accreditation established by a professional accrediting agency.

D. Agency for Healthcare Research and Quality – A federal agency within the U.S. Department of Health and Human Services that is charged with improving the safety and quality of the U.S. health care system through evidence-based research, training, measures, and data.

E. Annual Technical Report (ATR) – A detailed technical report that describes the manner in which the data from all activities conducted in accordance with 42 CFR § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO.

F. Application Program Interface (API) – Code that allows two software programs to communicate with each other.

G. Business Day(s) – The official working days of the week to include Monday through Friday. Official working days excluding State Holidays (see definition of "Normal State Business Hours" below).

H. COMAR – Code of Maryland Regulations available on-line at http://www.dsd.state.md.us/COMAR/ComarHome.html.

I. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care, overseen by the Agency for Healthcare Research and Quality (see 1.2.2).

J. Consumer Report Card (CRC) – A tool to assist Maryland Medicaid Participants in selecting one of the participating MCOs. Information in the Consumer Report Card includes performance measures from HEDIS®, the CAHPS survey, and the Value Based Purchasing Initiative

K. Continuity of Operations Plan (COOP) – COOP is an effort within an organization to ensure that its essential functions continue to be performed during a wide range of emergencies until normal operations can be resumed.

L. Contract – The Contract awarded to the successful Offeror pursuant to this RFP. The Contract will be in the form of Attachment M.

M. Contract Commencement - The date the Contract is signed by the Department following any required approvals of the Contract, including approval by the Board of Public Works, if such approval is required. See Section 1.4

N. Contract Monitor – The State representative for this Contract who is primarily responsible for Contract administration functions, including issuing written direction, invoice approval, monitoring this Contract to ensure compliance with the terms and conditions of the Contract, monitoring MBE and VSBE compliance, and achieving completion of the Contract on budget, on time, and within scope. The Contract Monitor may authorize in writing one or more State representatives to act on behalf of the Contract Monitor in the performance of the Contract Monitor's responsibilities. The Department may change the Contract Monitor at any time by written notice to the Contractor.

O. Contract Officer (CO) – The Office of Procurement and Support Services (OPASS) designated individual assigned to facilitate the procurement process. The Procurement Officer may designate the Contract Officer to conduct components of the procurement on behalf of the Procurement Officer

P. Contractor – The selected Offeror that is awarded a Contract by the State.

Q. Contractor Personnel – Employees and agents and subcontractor employees and agents performing work at the direction of the Contractor under the terms of the Contract awarded from this RFP.

R. Corrective Action Plan–A plan detailing improvements to an organization's processes that will be taken to eliminate causes of non-conformities or other problematic issues.

S. Data Breach – The unauthorized acquisition, use, modification or disclosure of State data, or other Sensitive Data.

T. Deeming–The process of determining that satisfaction of one requirement is sufficient to satisfy an equivalent requirement.

U. Department - Maryland Department of Health or MDH or the Department.

V. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - The federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents through 20 years of age, as defined by Omnibus Budget Reconciliation Act (OBRA) in 1989.

W. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthy Kids Review – An annual medical record review that collects and analyzes data to assess the timely delivery of EPSDT services to children and adolescents enrolled in an MCO.

X. eMMA – eMaryland Marketplace Advantage (see RFP Section 4.2).

Y. Encounter Data Validation (EDV) – Validation of the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under the fee-for-service reimbursement systems

Z. Enterprise License Agreement (ELA) – An agreement to license the entire population of an entity (employees, on-site contractors, off-site contractors) accessing a software or service for a specified period of time for a specified value.

AA. External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or their contractors furnish to Medicaid participants.

BB. External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs external quality review, other EQR- related activities as set forth in 42 CFR § 438.358, or both.

CC. Go-Live Date – The date, as specified in the Notice to Proceed, when the Contractor must begin providing all services required by this solicitation. See Section 1.4.

DD. Healthcare Effectiveness Data and Information Set (HEDIS®)– A tool developed by the National Committee of Quality Assurance that is used to measure performance on dimensions of care and service.

EE. HealthChoice– Maryland Medicaid's statewide mandatory managed care program, implemented in 1997 under the authority of Section 1115 of the Social Security Act.

FF. Health Insurance Portability and Accountability Act (HIPAA) – A federal law that establishes standards regarding privacy regulation and sets out specific and explicit rights that individuals have to access, make changes to and restrict the use of their protected health information.

GG. Information System – A discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of information.

HH. Information Technology (IT) – All electronic information-processing hardware and software, including: (a) maintenance; (b) telecommunications; and (c) associated consulting services.

II. Key Personnel – All Contractor Personnel identified in the solicitation as such that are essential to the work being performed under the Contract. See RFP Sections 3.10.

JJ. Local Time – Time in the Eastern Time Zone as observed by the State of Maryland. Unless otherwise specified, all stated times will be Local Time, even if not expressly designated as such.

KK. Managed Care Organization (MCO) – A certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; or a corporation that is a managed care system that is authorized to receive medical assistance prepaid capitation payments, enrolls only program recipients or individuals or families served under the Maryland Children's Health Program, and is subject to the requirements of Health-General Article, § 15-102.4, Annotated Code of Maryland.

LL. Medicaid Participant: An individual who receives benefits under the State Medical Assistance Program.

MM. Minority Business Enterprise (MBE) – Any legal entity certified as defined at COMAR 21.01.02.01B (54) which is certified by the Maryland Department of Transportation under COMAR 21.11.03.

NN. National Committee for Quality Assurance (NCQA) – A private, 501(c)(3) not-for-profit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation

OO. Normal State Business Hours - Normal State business hours are 8:00 a.m. – 5:00 p.m. Monday through Friday except State Holidays, which can be found at: www.dbm.maryland.gov – keyword: State Holidays.

PP. Notice to Proceed (NTP) – A written notice from the Procurement Officer that work under the Contract, project, Task Order or Work Order (as applicable) is to begin as of a specified date. The NTP Date is the start date of work under the Contract, project, Task Order or Work Order. Additional NTPs may be issued by either the Procurement Officer or the Contract Monitor regarding the start date for any service included within this solicitation with a delayed or non-specified implementation date.

QQ. NTP Date – The date specified in a NTP for work on Contract, project, Task Order or Work Order to begin.

RR. Offeror – An entity that submits a Proposal in response to this RFP.

SS. Participant – A person who has been certified as eligible for, and is receiving, Medicaid benefits.

TT. Performance Improvement Project (PIP) – A project designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care or non-clinical care areas that are expected to have a favorable effect on health outcomes. The PIP typically runs on a three-year cycle, at the discretion of the Department.

UU. Personally Identifiable Information (PII) – Any information about an individual maintained by the State, including (1) any information that can be used to distinguish or trace an individual identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

VV. Procurement Coordinator – The State representative designated by the Procurement Officer to perform certain duties related to this solicitation which is expressly set forth herein.

WW. Procurement Officer – Prior to the award of any Contract, the sole point of contact in the State for purposes of this solicitation. After Contract award, the Procurement Officer has responsibilities as detailed in the Contract (Attachment M), and is the only State representative who can authorize changes to the Contract. The Department may change the Procurement Officer at any time by written notice to the Contractor.

XX. Proposal – As appropriate, either or both of the Offeror's Technical or Financial Proposal.

YY. Protected Health Information (PHI) – Information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

ZZ. Quality – As it pertains to external quality review, the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge

AAA. Quality Assurance Liaison Committee (QALC) – This committee meets quarterly at the Department of Health and Mental Hygiene headquarters to review reports with MCOs,

discuss quality assurance activity cycles and timelines, answer MCO questions, and discuss ways to improve care for the HealthChoice program

BBB. Quality Improvement Organization (QIO) – A group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare, and who work under contract with the Centers for Medicare and Medicaid Services (CMS) to assist Medicare Providers with quality improvement and to review quality concerns for the protection of participants and the Medicare Trust Fund.

CCC. QIO-like Entity – An organization that has been deemed by CMS to meet the requirements for a QIO, but does not work under contract with CMS as a QIO.

DDD. Quality Strategy– A written strategy for assessing and improving the quality of managed care services offered by all MCOs.

EEE. Request for Proposals (RFP) – This Request for Proposals issued by the Maryland Department of Health (Department), with the Solicitation Number and date of issuance indicated in the Key Information Summary Sheet, including any amendments thereto.

FFF. Security Incident – A violation or imminent threat of violation of computer security policies, Security Measures, acceptable use policies, or standard security practices. "Imminent threat of violation" is a situation in which the organization has a factual basis for believing that a specific incident is about to occur.

GGG. Security or Security Measures – The technology, policy and procedures that a) protects and b) controls access to networks, systems, and data.

HHH. Sensitive Data - Means PII;PHI; other proprietary or confidential data as defined by the State, including but not limited to "personal information" under Md. Code Ann., Commercial Law § 14-3501(e) and Md. Code Ann., St. Govt. § 10-1301(c) and information not subject to disclosure under the Public Information Act, Title 4 of the General Provisions Article; and information about an individual that (1) can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; or (2) is linked or linkable to an individual, such as medical, educational, financial, and employment information.

III. Service Level Agreement (SLA) - Commitment by the Contractor to the Department that defines the performance standards the Contractor is obligated to meet.

JJJ. Software - The object code version of computer programs licensed pursuant to this Contract. Embedded code, firmware, internal code, microcode, and any other term referring to software that is necessary for proper operation is included in this definition of Software. Software includes all prior, current, and future versions of the Software and all maintenance updates and error corrections. Software also includes any upgrades, updates, bug fixes or modified versions or backup copies of the Software licensed to the State by Contractor or an authorized distributor.

KKK. Solution - All Software, deliverables, services and activities necessary to fully provide and support the RFP scope of work. This definition of Solution includes all System Documentation developed as a result of this Contract. Also included are all Upgrades, patches, break/fix activities, enhancements and general maintenance and support of the Solution and its infrastructure.

LLL. State – The State of Maryland.

MMM. System Availability – The period of time the Solution works as required excluding non-operational periods associated with planned maintenance.

NNN. Systems Performance Review (SPR) – An assessment of the structure, process, and outcome of each Maryland MCO's internal quality assurance programs, in order to ensure that the services provided to the enrollees meet the standards set forth in the federal and Maryland laws and regulations governing the HealthChoice program.

OOO. Technical Safeguards – The technology and the policy and procedures for its use that protect State Data and control access to it.

PPP. Third Party Software – Software and supporting documentation that:

1) are owned by a third party, not by the State, the Contractor, or a subcontractor;

2) are included in, or necessary or helpful to the operation, maintenance, support or modification of the Solution; and

3) are specifically identified and listed as Third Party Software in the Proposal.

QQQ. Total Proposal Price - The Offeror's total price for goods and services in response to this solicitation, included in Financial Proposal Attachment B – Financial Proposal Form.

RRR. Upgrade - A new release of any component of the Solution containing major new features, functionality and/or performance improvements.

SSS. Validation – The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

SSS. Value Based Purchasing Initiative (VBPI) – A quality improvement initiative that promotes high-quality service delivery by aligning MCO incentives with performance\measures related to the provision of health services, increased access to care, and administrative efficiency

TTT. Veteran-owned Small Business Enterprise (VSBE) – A business that is verified by the Center for Verification and Evaluation (CVE) of the United States Department of Veterans Affairs as a veteran-owned small business. See Code of Maryland Regulations (COMAR) 21.11.13.

Appendix 2. – Offeror Information Sheet

See link at http://procurement.maryland.gov/wp-content/uploads/sites/12/2018/04/Appendix2-Bidder_OfferorInformationSheet.pdf.

Appendix 3. – EQRO Resources

CMS EQR Protocols

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html

https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

Grievances, Appeals, and Denials Instructions and Templates

https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20Focused%20Review%20Report%20on%20Grievances,%20Appeals,%20and%20Denials.pdf

HealthChoice Consumer Report Card (English)

https://mmcp.health.maryland.gov/healthchoice/Documents/Consumer%20MCO%20Report%202020.pdf

HealthChoice Consumer Report Card (Spanish)

https://mmcp.health.maryland.gov/healthchoice/Documents/Consumer%20MCO%20Report%20Spanish.pdf

Maryland Healthy Kids/EPSDT Program Information

https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx

Maryland Healthy Kids Preventive Health Schedule

https://mmcp.health.maryland.gov/Documents/Maryland%20EPSDT%20Schedule-01-01-20%20final_%20(1)HealthRiskAssessment2020%20(1).pdf

Maryland 2019 EQRO Annual Technical Report

https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20MD%20ATR%20FINAL_508.pdf

2019 Network Adequacy Validation Report

https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20Network%20Adequacy%20Validation%20Report.pdf

Appendix 4. – EPSDT/Healthy Kids Review Standards

Component I: Health & Development History				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
Recorded medical history*** **Note:** To be documented annually – within the calendar month of the last notation (ex: last note made on 8/3/06, can be documented as current up to 9/1/07)	1. If medical issues surface within the record, the information should be summarized in one place: • Chronic and/or acute illness; i.e. allergies • Surgeries and/or injuries • Nutrition problems, i.e. eating disorders, obesity, malnourishment • Sexual history of preadolescent/adolescent (age 11 years and older, earlier if indicated) • Medication history with notation of allergic reactions; or 2. Problem list used and kept up-to-date; or 3. History summarized in one location on a standardized form with yearly update noted; or 4. Initial history completed and update documented on DOS – "ROS", "no problems" or "F/U for problems" **NOTE:** For infants up to age one, in the absence of any health issues, the perinatal history is accepted as part of the history.	1. Initial history completed but no documentation of recent identified medical problems; or 2. Information present throughout the chart but not summarized in one location; or 3. No initial history completed but "update" documented on DOS – "ROS", "no problems" or "F/U for problems or similar notation"	1. Medical history not documented on child/adolescent new to practice	

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
Recorded family history*** **Note:** Includes the following: • Biological family: mom, dad, siblings • Extended family: grandparents, aunts, uncles **Note:** To be documented annually – within the calendar month of the last notation (ex: last note made on 8/3/06, can be documented as current up to 9/1/07)	1. Documentation of any of the following within a year of DOS: • Chronic illness i.e. hypertension, diabetes, HIV, caner • Acute illnesses • Hereditary disorders: i.e. sickle cell, deafness • Past history of violence, substance abuse/addictions • Learning disabilities • Genogram noted in record; or 2. Child in Foster Care/Adopted child; or 3. History summarized in one location on a standardized form with <u>yearly updates noted beginning at age 2 years</u>; or 4. Documentation that the Family History is "non-contributory" or "negligible" with annual updates	1. Yearly update missing after 2 years of age; or 2. No initial family history summary completed <u>but</u> "update" documented on DOS – "Same" or "no changes" or similar notation	1. Family history not documented; or 2. Child new to practice – no history	

Recorded perinatal history*** **Note:** Required up to 2 years of age **Note:** A copy of the hospital delivery record is acceptable	1. At least *two* items are documented: • Pregnancy History: substance abuse, smoking, medications, HIV • Birth History: type of birth, birth weight, place of birth; or 2. Child in Foster Care/Adopted child	1. Only *one* item documented	1. Peri-natal history not documented	

****REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
Recorded maternal depression screening **Note:** Required at child's 1, 2, 4, and 6 month visits. Scored as baseline in 2018 and 2019.	1. Maternal depression screening tool (PHQ-9, EPDS, PDSS, Beck Depression Inventory-II or other approved tool) must be used at the 1, 2, 4, and 6 month visits; or 2. Providers may "pre-screen" with PHQ-2 to determine if longer standardized screening tool is needed	1. Incomplete screening tool; or 2. No screening tool used but maternal depression assessment documented in progress notes	1. No maternal depression screening tool or documentation in progress notes	1. Child brought to appt. by someone other
Recorded psycho-social history*** **Note:** To be documented on DOS or within a year after the DOS – based on the	1. Initial summary completed and updates noted on the DOS or within a year after DOS; or 2. Summary and/or assessment on the	1. Psycho-social history done at initial visit – but no update documented within 1 year; or	1. Psych-social history not documented	

calendar month of the last notation (ex: last note made on 8/3/06, can be documented as current up to 9/1/07) **Note:** Source can be a registration form as long as it includes required items **Note:** 2nd page of Mental Health Questionnaire has psycho-social content	DOS should include documentation of <u>any combination of *two*</u> of the following: • Family profile – those living in home, care giver(s), child care arrangements • Living arrangements – relative's home, own home, apartment, shelter • Psycho-social stressors – foster care, parental divorce, economic and/or legal problems, substance abuse in home • Exposure to violence – home, school or community ("gangs", cyber-abuse, bullying) • Environmental factors – exposure to smoke, pets; or 3. "Foster care" noted as a stand-along item on the ***initial*** placement PE with a social worker	2. No initial psycho-social history completed <u>but</u> "update" documented on DOS as "Same" or "no changes" or similar notation; or 3. Only <u>*one*</u> item documented unless child was seen for the initial foster care placement PE with a social worker		

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
Recorded Developmental Surveillance/History **Note:** If a delay is noted, the type of delay should be noted **Note:** Educate providers on AAP Policy for developmental screening	**0-5 Years** 1. Documented developmental surveillance on DOS that includes all four of the following skill areas: speech/language, gross motor, fine motor, and social; or 2. Standardized developmental screening tools may be used with results of all 4 milestones/domains or at least 10 age-appropriate questions documented	**0-5 Years** 1. Fewer than four skill areas noted; or 2. Identified developmental delay without developmental history obtained	**0-5 Years** 1. No developmental surveillance documented	
Recorded Developmental Screening Tool*** **Note:** Required at 9, 18, and 24-30 month visits **Note:** Look back at previous visits to see if screening was completed. Ex: If child is 12 months old, look for 9 month screening).	**0-3 Years** 1. Developmental screening tool (ASQ or PEDS) (recommended) must be used at 9, 18, and 24-30 month visits; or 2. Other approved tools • Battelle Developmental Inventory Screening Tool, 2nd ed. • Brigance Screens-II • Early Screening Inventory – Revised	**0-3 Years** 1. Incomplete screening tool 2. Use of non-approved screening tool.	**0-3 Years** 1. No developmental screening tool	

	• FirstSTEP Preschool Screening Tool			
Recorded Autism Screening Tool*** **Note:** Required at 18 and 24-30 month visits **Note:** Look back at previous visits to see if screening was completed. Ex: If child is 20 months old, look for 18 month screening).	**0-3 Years** 1. Autism screening tool (M-CHAT-R) must be used at 18 and 24-30 month visits	**0-3 Years** 1. Incomplete screening tool	**0-3 Years** 1. No autism screening tool	
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
Recorded Developmental Surveillance/History **Note:** To be documented on DOS or within a year after the DOS – based on the calendar month of the last notation (ex: last note made on 8/3/06, can be documented as current until 9/1/07)	**6-20 Years** 1. Notation of any two of the following: • School grade/performance • Social skills • Family relations and/or peer relations • Self-help skills • Cognitive skills • Extracurricular activities • Future plans/goals (college, work, etc.); or 2. Documented developmental surveillance results on DOS – "No problems", "normal", "WNL"	**6-20 Years** 1. Identified developmental delay without developmental surveillance/history obtained; or 2. Only one item noted	**6-20 Years** 1. No developmental surveillance documented on DOS or at any other visit within a year after the DOS	

Recorded Mental/Behavioral Health Assessment **Note:** Mental Health Assessments and Developmental Surveillance are considered the same prior to 3 years of age **Note:** To be documented <u>on DOS or within a year after the DOS</u> – based on the calendar month of the last notation (ex: last note made on 8/3/10, can be documented as current until 9/1/11)	**<u>3-20 Years</u>** 1. Results of mental/behavioral health assessment ("at risk"/"positive" or "no risk"/"negative"/" WNL") documented on the date of service and/or within the year; or 2. Identified problems noted with referral and/or counseling appropriately documented; or 3. Follow-up after referral documented in the chart; or 4. At least <u>two</u> of the following: • Affect • Depression/suicide thoughts • Social interactions – "loner" tendency • Behavior – "acting out" at school or home • Eating disorders • Relationships with peers and family; or 5. Under mental health care within the year; or	**<u>3-20 Years</u>** 1. "At risk" or "positive" results documented but no referral and/or counseling noted; or 2. Only <u>one</u> item noted	**<u>3-20 Years</u>** 1. Mental health assessment not documented on DOS or at any other visit within the year	
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**

	6. School behavioral assessment in chart and dated within a year of the DOS; or 7. Other approved tool: • Pediatric Symptom Checklist (PSC-Y)			
Recorded Substance Use Assessment **Note:** Required at 11 years and older, or if indicated at younger age **Note:** Must be documented by or on the DOS **Note:** Examples include: PACES = pot, alcohol, caffeine + cigarettes, exercise, and sex DATES = drugs, alcohol, tobacco, exercise, and sex Tobacco, vaping/electronic cigarettes	1. Substance abuse assessment for drugs and alcohol results ("at risk"/"positive" or "no risk"/"negative") documented beginning on the initial visit – 11 years and older and yearly thereafter; or 2. "At risk" or "positive" assessment counseled and/or referred appropriately; or 3. Follow-up after referral documented in the chart; or 4. Denial of drugs, alcohol, and tobacco, vaping/electronic cigarettes; or 5. Completed validated tool (CRAFFT or CAGE-AID tool recommended)	1. "At risk" or "positive" results documented on DOS but no referral and/or counseling noted; or 2. "At risk" or "positive" assessment within the year but no notation of follow-up after referral and/or counseling; or 3. Only the use of 1-2 substances (drugs, alcohol, or tobacco/vaping/ electronic cigarettes) assessed; or 4. Drug or alcohol education with no assessment of substance abuse	1. Substance use assessment not documented on DOS or any other visit prior to DOS	

Depression Screening	**11-20 Years** 1. Completed validated mental health TEEN SCREEN (PHQ-9) or HEAD screen (schools) beginning at the age of 11 (Recommended); or 1. Pediatric Symptom Checklist (PSC-Y); or 2. Center for Epidemiological Studies Depressions Scale for Children (CES-DC); or 3. Beck Depression Inventory (BDI)	**11-20 Years** 1. Incomplete screening tool 2. Use of PHQ-2 screening tool.	**11-20 Years** 1. Depression screen not documented on DOS or any other visit prior to DOS	

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

Definitions	
Surveillance	Questioning and/or observations made by a provider based on expertise and clinical judgment and/or use of non-validated questionnaires for purpose of determining further screening and/or evaluation
Screen	Use of standardized and validated questionnaires, tests and/or equipment such as audiometer to determine if a patient is "at risk" for a specific problem
Evaluation	More intense and length interventions by primacy care or specialty providers to established a specific diagnosis

Component II: Comprehensive Unclothed Physical Exam				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
Documentation of minimum 5 systems examined	1. Documentation of <u>five or more</u> of the following systems:	1. <u>Fewer than five</u> systems documented; or	1. No evidence of a documented	

	• Heart, lungs, (HEENT or EENT), eyes, ears, nose, throat, abdominal genitals, skeletal-muscle, neurological, skin, head, face	2. PE "WNL" or "normal"	physical exam by systems	
Vision assessment*** **Observations by the PCP** determined by: 1. **0-35 months –** Examination of the eyes 2. **0-5 years** – Developmental assessment 3. **0-20 years** – Questioning of parent, child or adolescent 4. **3 years and older – Screening** with objective "tools" to determine if the child/adolescent is seeing	**0-35 Months** 1. Physical examination of the eyes with documented results: "EENT," "gaze conjugate," red reflex, eye infection/drainage, "eyes normal or WNL," appears to see; or 2. Vision assessed as part of development: eye/hand (fine motor) coordination such as "copies," "pincer," "points," documented **3-20 Years** 1. Documented vision assessment ("normal findings or WNL") or vision screen results or documented attempted screening of an uncooperative child. (Photo screen is	**3-20 Years** 1. Physical examination of the eyes with documented results: "eyes WNL," "EENT normal," but vision assessment results not specifically documented; or 2. Abnormal findings with no referral to a specialist or no follow-up	1. No documented vision assessment (objective or subjective)	

	considered a vision assessment) **School Aged Children** 1. Documentation that a school vision screening was done within 1 year, with normal results **All Ages** 1. Conditions documented by PCP that affect vision and require follow-up vision screen (use of "tools") and/or referral to specialty providers: amblyopia, strabismus or heterotopia, color deficiency, retinopathy or prematurity, myopia, hyperopia, astigmatism			
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
Hearing assessment*** **Observations by the PCP** that include: 1. **0-35 months –** Examination of the ears 2. **0-5 years –** Developmental assessment 3. **0-20 years -** Questioning of	**0-35 Months** 1. Physical examination of the ears with documented results: "ENT," "ears normal," "TMs mobile and clear," appears to hear; or 2. Hearing assessed as part of development: speech	**3-20 Years** 1. Physical examination of the ears with documented results: "ears WNL," ENT normal," but hearing assessment not specifically documented; or 2. Abnormal findings but no	1. No documented hearing assessment (objective or subjective)	

parent, child or adolescent 4. Review of Systems (ROS) can include assessment of hearing 5. **3 years and older – Screening** with objective "tools" to determine if the child/adolescent is hearing appropriately	development documented i.e. "Laughs, babbles, "turns to noise" or speech noted **3-20 Years** 1. Documented hearing assessment ("normal findings or WNL") **or** hearing screen results or documented attempted screening of an uncooperative child **School Aged Children** 1. Documentation that a school hearing screening was done within 1 year, with "normal results" documented	referral to specialist or no follow-up		
Nutritional Status	1. Current dietary summary in chart; or 2. Documentation of two or more of the following: • Eating habits including "picky eater", "good appetite" and behaviors, eats 3 meals/day • Physical activities • Nutritional risk factors – overweight, underweight,	1. Fewer than two topics documented	1. No documented nutritional assessment	

	eating disorders (anorexia, bulimia), etc. • Developmental readiness			
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
	• Nutritional education/need for exercise • Documented change in diet; or 3. Specify food groups			
Conducted oral assessment **Note:** This assessment is part of the PE not a ROS (Review of Systems)	1. Documentation of <u>at least one</u> of the following: • "Dental WNL" as one of systems reviewed • Notation of condition of oral cavity/mouth and/or teeth • Notation of # of teeth as they erupt in infancy	1. Only HEENT or ENT documented	1. No documented oral assessment	
Measured height	1. Documented height on date of service	N/A	1. Height missing on date of service	
Graphed height correctly	1. Height graphed at <u>correct</u> year, month, and measurement on date of service; or 2. Percentile noted on date of service; or	N/A	1. Graphs missing; or 2. Graphed incorrectly – wrong age or measurement	

	3. BMI calculated and/or graphed (age 2 years and older)			
Measured weight	1. Documented weight on date of service	N/A	1. Weight missing on date of service	
Graphed weight correctly	1. Weight graphed at correct year, month, and measurement on date of service; or 2. Percentile noted on date of service; or 3. BMI calculated and/or graphed (age 2 years and older)	N/A	1. Graphs missing; or 2. Graphed incorrectly – wrong age or measurement	
BMI Percentile (2 years and older)	1. BMI Percentile calculated correctly and documented on DOS	N/A	1. BMI not calculated and documented on DOS	

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
BMI Graphing (2 years and older)	1. BMI Calculation graphed correctly; or 2. BMI Calculation correctly noted on DOS	N/A	1. BMI not graphed	
Measured head circumference	1. Head circumference measured on date of service through age 24 months	N/A	1. Head circumference missing; or 2. Graphed incorrectly – wrong age or measurement	

Graphed head circumference	1. Head circumference graphed (through 24 months); or 2. Percentile noted on date of service	N/A	1. Head circumference not graphed; or 2. Graphed incorrectly – wrong age or measurement	
Measured blood pressure	1. Measured and recorded B/P on all children 3 years and older; or 2. Documented attempt to obtain B/P of an uncooperative child.	N/A	1. No documented blood pressure measurements	
Newborn metabolic screen*** **Note:** Results scored to 6 months of age	1. Documented results of second test in record for all infants; or 2. Valid test results dated up to 8 weeks of age; or 3. Infant older than 8 weeks of age new to practice and practice unable to verify newborn metabolic screen test results	1. Screen ordered but no results in chart	1. No test ordered; or 2. No test results from second PKU; or 3. Test done after 8 weeks of age (test not valid)	1. Child younger than 8 weeks of age

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
Recorded Tb Risk Assessment*** **Note:** Required at 1, 6, and 12 months of age and annually thereafter	1. Tb risk assessment results ("at risk"/"positive" or "no risk"/"negative"/WNL") noted in the record at the 1 month visit and annually thereafter; or 2. "At risk" or "positive" assessments screened with PPD and/or chest	1. "At risk" or "positive" Tb risk assessment documented but no PPD done; or 2. Referred to lab or PPD placed but non results in record; or	1. No documented Tb risk assessment and no PPD placement; or 2. No referral to lab on DOS	

Note: *Preventive Screen Questionnaire* must be dated. 6 month Tb risk assessment scored as baseline in 2018 and 2019. Scored in 2020.	x-ray and results noted in the record; or 3. PPD, Quantiferon, or T-Spot results within the year of the DOS can substitute for assessment; or 4. Tb risk assessment on DOS or within 1 year of initial visit of child older than 12 months; or 5. Currently undergoing treatment for Tb;	3. Tb addressed in family history completed within the year		
Recorded Cholesterol Risk Assessment **Note:** Required from 2 years of age and annually thereafter **Note:** *Preventative Screen Questionnaire* must be dated	1. Cholesterol risk assessment results ("at risk"/"positive" or "no risk"/"negative" or "WNL") noted in the record at least annually; or 2. "At risk" or "positive" assessments counseled and/or referred for blood test and results noted in record; or 3. Referral for Cholesterol testing on DOS with results documented within 1 year on chart; or 4. Normal cholesterol blood test results within 5 years can substitute for assessment; or 5. No new risk factors on recent preventive health screen, including family history update	1. "At risk" or "positive" cholesterol risk assessment documented but no counseling or blood testing done; or 2. Referred to lab or blood test ordered but no results in record; or 3. Incorrectly assessed as no risk, but medical and/or family history indicates risk	1. No documented cholesterol risk assessment; or 2. No referral to lab on DOS	
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**

9-11 year old Dyslipidemia lab test per Schedule*** Scored as baseline in 2018	1. Blood test documented between 9 and 11 years of age. • Non HDL-C is needed (total cholesterol and HDL or full lipid panel required for this)	1. Documented results of one dyslipidemia blood test between 9 and 11 years old	1. No documented test result between 9 and 11 years of age	1. Child younger than 11 years of age
18-21 year old Dyslipidemia lab test per Schedule*** Scored as baseline in 2018	1. Blood test documented between 18 and 21 years of age. • Non HDL-C is needed (total cholesterol and HDL or full lipid panel required for this)	1. Documented results of one dyslipidemia blood test between 18 and 21 years old	1. No documented test result between 18 and 21 years of age	1. Child younger than 21 years of age
Conducted lead risk assessment **Note:** Assessments required at every preventive care visit from 6 months to 6 years regardless of child's zip code **Note:** *Preventive Screen Questionnaire* must be dated	1. Documentation of lead risk assessment results on DOS; or 2. Referral to lab for blood lead level when risk assessment is "at risk" or "positive"; or 3. Blood lead test result documented in chart is a proxy for lead risk assessment within one year after the date of service	1. "At risk" or "positive" lead risk identified but no referral to lab for blood lead test on DOS but subsequent f/u documented; or 2. Incomplete lead risk assessment on DOS – not all questions addressed	1. No lead risk assessment results documented on DOS; or 2. No date on questionnaire to validate when assessment was completed; or 3. No subsequent f/u for identified risks after DOS	
12 Month Blood lead test/Screen per Schedule*** **Note:** Required at 12 months	1. For 12 month visit – test results documented between 9-23 months of age; or 2. On the 24 month visit only – If a child is new to the practice on this visit, *score the 12 month blood lead test as complete using note*		1. No documented test between 9-23 months of age	1. Child younger than 23 months of age

	"Patient is new to the practice"			
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
24 Month Blood lead test/Screen per Schedule*** **Note:** Required at 24 months	1. Test documented between 24-35 months of age		1. No documented test result between 24-35 months of age	1. Child younger than 35 months of age
"3-5 Year" Blood Lead Test*** **Note:** Baseline test required between 36-71 months of age when the 24 month (24-35 months) lead test result is not documented	1. Blood lead results documented on or after 24 months of age; or 2. Baseline blood lead results documented after initial visit to practice for children between ages 2 through 5 years when results from previous provider are not available; or 3. Blood lead test results documented on DOS as a result of a new positive risk factor identified	1. Only "12 month" (9-23 months) test result documented 2. Unsuccessful lab draw.	1. No blood lead results documented on or after 24 months of age; or 2. New risk factor but no lead test results	1. Child younger than 6 years of age
Referral to lab for blood lead test **Note:** A test result within the appropriate age range is a proxy for the referral	1. Documented referral/lab slip in chart for 12 month blood lead test; or 2. Documented referral/lab slip at 15 and 18 months if 12 month blood test is missing; or 3. Documented referral/lab slip in chart for 24 month blood lead test; or 4. Documented referral/lab slip at 3, 4, and 5 years if 24	1. No referral/lab slip documented, but request for lead test results from previous provider is documented on DOS (includes signed release for a medical record request on DOS)	1. No referral/lab slip in chart and 2. No documented request for test results from previous provider	

	month blood lead test is missing; or 5. Documented referral/lab slip for repeat lead test within 3 months for BLL between 5-9 µg/dL; or 6. Documented referral to MCO/LHD for assistance in getting child tested for blood lead level; or 7. Documented parental refusal for lead test			

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
Conducted anemia risk assessment **Note:** Assessments required annually at every preventive care visit beginning at the age of 11.	1. Documentation of anemia risk assessment results on DOS ; or 2. Referral to lab for one hemoglobin (Hgb) or hematocrit (Hct) test when risk assessment is "at risk" or "positive"; or 3. Blood Hgb or Hct test result documented in chart is a proxy for anemia risk assessment within one year after the date of service	1. "At risk" or "positive" anemia risk identified but no referral to lab for Hct or Hgb blood test on DOS but subsequent f/u documented; or 2. Incomplete anemia risk assessment on DOS – not all questions addressed	1. No anemia risk assessment results documented on DOS; or 2. No date on questionnaire to validate when assessment was completed; or 3. No subsequent f/u for identified risks after DOS	
12 Month Anemia test per Schedule***	1. Test results documented in chart per schedule: • For 12 month visit	1. Test ordered at appropriate age per Schedule, including orders	1. No test result documented in chart	1. Child younger than 23

Note: Required at same time as lead test	– one hemoglobin (Hgb) or hematocrit (Hct) test result documented before 24 months; or 2. Documented parental refusal for anemia test; or 3. Catch-up Hgb or Hct test results documented according to the *Schedule of Preventive Health Care* (15 and 18 months for 12 month test, 3,4 and 5 years for 2 year test)	for catch-up testing but results not documented; or 2. Follow-up tracking of referral to lab documented by provider; or 3. When child is new to provider - anemia test results requested from previous provider on initial well child visit accepted once; or	2. Unsuccessful lab draw.	months of age

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

Component III: Laboratory Tests/Screen and Risk Assessments by Questionnaire				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
		4. Child known prior to 12 months of age but only one test result is documented at the 2-5 year visits.		
24 Month Anemia test per Schedule*** **Note:** Required at same time as lead test	1. Test results documented in chart per schedule: • For 2 year old visit – two hemoglobin (Hgb) or hematocrit (Hct) test results required or if new at 2 years, only one result is required between 24-35	1. Test ordered at appropriate age per Schedule, including orders for catch-up testing but results not documented; or 2. Follow-up tracking of referral to lab	1. No test result documented in chart 2. Unsuccessful lab draw.	1. Child younger than 35 months of age

	months; or 2. Documented parental refusal for anemia test; or 3. Catch-up Hgb or Hct test results documented according to the *Schedule of Preventive Health Care* (3, 4, and 5 years for 2 year test)	documented by provider; or 3. When child is new to provider - anemia test results requested from previous provider on initial well child visit accepted once; or 4. Child known prior to 12 months of age but only <u>one</u> test result is documented at the 2-5 year visits		

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
3 -5 Year Anemia test per Schedule*** **Note:** Required at same time as lead test	1. Test results documented in chart per schedule: • For 3-5 year visits – <u>one</u> Hgb or Hct test result is required after the age of 2 years; or 2. Documented parental refusal for anemia test; or 3. Catch-up Hgb or Hct test results documented according to the *Schedule of Preventive Health Care*	1. Test ordered at appropriate age per Schedule, including orders for catch-up testing but results not documented; or 2. Follow-up tracking of referral to lab documented by provider; or 3. When child is new to provider – anemia test	1. No test results documented in chart 2. Unsuccessful lab draw.	1. Child younger than 6 years of age

		results requested from previous provider on initial well child visit accepted once; or 4. Child known prior to 12 months of age but only <u>one</u> test result is documented at the 2-5 year visits		
Recorded STI/HIV Risk Assessment **Note:** Required at 11 years of age, or younger if indicated, and annually on DOS	1. STI/HIV risk assessment results ("at risk"/"positive" or "no risk"/"negative"/"WNL") noted in the record at least annually; or 2. Positive assessments referred for STI/HIV blood tests and results noted in record; or	1. Positive STI/HIV risk assessment documented on DOS but no referral for testing or counseling done; or	1. No documented STI/HIV risk assessment **Note:** *if referred to LHD for lab test, PCP may not get results*	

******REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
Note: Could be in the form of: PACES = pot, alcohol, caffeine + cigarettes, exercise, and <u>sex</u> DATES = Drugs, alcohol, tobacco, exercise, and <u>sex</u>	3. STI/HIV test results within the year can substitute for assessment (i.e. RPR, HIV, GC, Chlamydia, HPV); or 4. Education for STI/HIV noted on DOS in the health education component under sexuality; or 5. Denies sexual activity or partner on DOS; or 6. Documented patient/parent refusal for testing on DOS; or	2. "Sexually active" noted, without further assessment/ education; or 3. No risk assessment completed but referral to lab documented and/or tests ordered		

	7. Referred to LHD STI clinic or GYN for follow-up testing			
HIV test per Schedule*** **Note:** One lab test required between 15-18 years of age Scored as baseline in 2018 and 2019 Scored in 2020	1. Documented results of one HIV lab test between 15 and 18 years of age	1. Test was ordered but no results documented in record	1. No test results documented in record	1. Child younger than 18 years of age

****REFER TO THE MARYLAND HEALTHY KIDS PREVENTIVE HEALTH SCHEDULE FOR DUE DATES***

Definitions	
	Questioning and/or observations made by a provider based on expertise and clinical judgment and validated questionnaires for purpose of determining further screening and/or evaluation
	Use of standardized and validated questionnaires, tests and/or equipment such as audiometer to de is "at risk" for a specific problem
	More intense and lengthy interventions by primary care or specialty providers to establish a speci

Component IV: Immunizations				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
Hepatitis B Vaccine(s) per schedule **Note:** Merck's Recombivax is a 2 dose schedule, using the adult dosage, for the previously unvaccinated 11-15 yr. old adolescent	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by date of review (DOR); or 2. Parent refusal documented; or 3. Vaccine shortage reported by practice; or	1. Series started but not up-to-date on DOS or/by DOR	1. No record of Hepatitis B in chart	

	4. Positive Hepatitis profile documented (HbsAB)			
DTaP (DT) Vaccine(s) per schedule **Note:** Persons not fully immunized age 7-18: One dose of Tdap (Adacel) is to be utilized. **Catchup**: For ages 7-10 Tdap is administered. **Tdap:** Boostrix (GlaxoSmithKline) -can be given at 10-18 years Adacel (Sanofi pasteur) - can be given at 11-21 years	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by DOR; or 2. Parent refusal documented; or 3. Vaccine shortage documented by practice	1. Series started but not up-to-date on DOS or/by DOR	1. No record of DTaP/DT om chart	
HIB Vaccine(s) per schedule **Note:** If PedvaxHibor ComVax, both Merck, administered at 2 and 4	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by DOR; or	1. Series started but not up-to-date on DOS or/by DOR	1. No record of HIB in chart	

Note: For children with Immunization delays, always refer to the "Catch-Up" schedule of the Maryland Department of Health Recommended Childhood and Adolescent Immunization Schedule to determine whether catch-up vaccines were administered according to schedule.

Component IV: Immunizations (Continued)				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
months, no 6 month dose is required	2. Parent refusal documented; or			

Note: Series should be completed by 5 yrs. of age	3. One dose of HIB given at 15 months or older becomes last dose required (even if it was the initial dose); or 4. Vaccine shortage documented by practice			
Pneumococcal Conjugate Vaccine (PCV-13 [Prevnar]) per schedule **Note**: 4 doses = complete series by 12-23 months of age **or** one final dose between 24-59 months of age for any incomplete series	1. Up-to-date per schedule for ages 2-23 months if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by DOR; or 2. One dose of PCV-13 given at 24 months or older becomes last dose required (even if it was the initial dose); or 3. Parent refusal documented; or 4. Vaccine shortage reported by practice	1. Series started but not up-to-date on DOS or/by DOR	1. No record of PCV-13 in chart	
Polio Vaccine(s) (IPV) per schedule	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by DOR; or 2. Parent refusal documented; or 3. Vaccine shortage documented by practice	1. Series started but not up-to-date on DOS or/by DOR	1. No record of Polio in chart	

MMR Vaccine(s) per schedule **Note:** Second dose can be given up to age 18-20	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS	1. Series started but not up-to-date on DOS or/by DOR; or	1. No record of either 1st or 2nd MMR as appropriate for age; or	

Note: For children with Immunization delays, always refer to the "Catch-Up" schedule of the Maryland Department of Health Recommended Childhood and Adolescent Immunization Schedule to determine whether catch-up vaccines were administered according to schedule.

Component IV: Immunization (Continued)				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
	• If age specific dose not given on DOS, given by DOR; or 2. Parent refusal documented; or 3. Vaccine shortage documented by practice; or 4. Serological evidence of immunity to Measles, Mumps, and Rubella; or 5. Administered no more than 4 days before the 1st birthday	2. First dose given more than 4 days before 1st birthday; or 3. Serological evidence of immunity for only one or two of the three diseases	2. No record of either 1st or 2nd MMR as appropriate for age; or 3. No serological evidence of immunity to any of the three diseases	
Varicella Vaccine(s) (VAR) per schedule	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by DOR • 2nd dose is administered by the 7th birthday • Children/adolescents older than 7 years should have 2 documented doses by or on DOS or/by DOR	1. First dose given more than 4 days before 1st birthday; or 2. Children/ adolescents older than 7 years who received only the 1st dose, no 2nd dose received by or on DOS or/by DOR; or 3. For adolescents	1. No record of Varicella vaccine; or 2. No documented history of chickenpox disease; or 3. No blood titer results	

	• Previously unvaccinated adolescent 13 years of age or older – 2 documented doses at least 4 weeks apart; or 2. History of chickenpox documented in the record; or 3. Parent refusal documented; or 4. Vaccine shortage documented by practice; or 5. Serological evidence (blood titer) of immunity to chickenpox documented; or 6. Administered no more than 4 days before the 1st birthday	13 years or older the 2-dose series was started but not up-to-date on DOS or/by DOR		

Note: For children with Immunization delays, always refer to the "Catch-Up" schedule of the Maryland Department of Health Recommended Childhood and Adolescent Immunization Schedule to determine whether catch-up vaccines were administered according to schedule.

Component IV :Immunizations (Continued)				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
TDAP per schedule DUE AGE 11-12 years of age **Note:** Tdap: Boostrix (GlaxoSmithKline)- Can be given at 10-20 years Adacel (Sanofi Pasteur) Can be given at 11-20 years	1. Administered by 13 years – as long as it is at least 5 years after last recorded DTaP/DT/DTP; or 2. Up-to-date if: • Scheduled age specific dose of immunization was given DOS • Age specific dose not given on DOS, given by DOR; or 3. Vaccine shortage reported by practice; or	N/A	1. No record of Td or Tdap in chart; or 2. Not administered by age 13 or DOS; or 3. Ordered, but not administered	

	4. If the 1st booster is given earlier (such as in the case of an injury), the next booster of Td is not needed for 10 years; or 5. Parent refusal documented			
Influenza (flu) Vaccines **Note:** Score ages 6 months through 20 years	1. Children 6 months through 20 years of age up-to-date if they received 1 dose given during current or most recent flu season (September through April) by DOR; or 2. Parent refusal documented; or 3. Vaccine shortage reported by practice	1. Children vaccinated in previous flu season(s) but not during most recent flu season under review; or 2. Patient advised/ scheduled to return for vaccination but did not keep appointments	1. No record of vaccine given to a child 6 months through 20 years of age; or 2. Ordered, but not administered; or 3. Patient not advised/ scheduled to return for vaccination	1. DOS occurred in May, June, July, or August
Meningococcal (MCV4) Vaccine per schedule	1. Administered at age 11-12 years with Booster at age 16-20. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS; or	N/A	1. No record of MCV4 vaccination in chart; or	

Note: For children with Immunization delays, always refer to the "Catch-Up" schedule of the Maryland Department of Health Recommended Childhood and Adolescent Immunization Schedule to determine whether catch-up vaccines were administered according to schedule.

Component IV: Immunizations (Continued)				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
RotaTeq (RV5) – 3 doses required (administered prior to 32 weeks of age)				

Note: If child received RV1 and RV5 for either of first two doses, a 3rd dose of RV is required				
Human Papillomavirus (HPV) **Note:** • Administer a 2-dose series of HPV vaccine. The first does is routinely recommended at 11-12 years old. The second dose of the vaccine should be administered 6 to 12 months after the first does. Vaccination with the two-dose series can be started at age 9 years through age 14 years. • Teens and young adults who start the series later, at ages 15 through 26 years	1. Up-to-date if: • Scheduled age specific dose of immunization was given on DOS • If age specific dose not given on DOS, given by DOR; or 2. Parent refusal documented; or 3. Vaccine shortage reported by practice	1. Series started but not up-to-date on DOS or/by DOR	1. No record of HPV vaccination in chart	

Note: For children with Immunization delays, always refer to the "Catch-Up" schedule of the Maryland Department of Health Recommended Childhood and Adolescent Immunization Schedule to determine whether catch-up vaccines were administered according to schedule.

ELEMENT	COMPLETE	INCOMPLETE	MISSING	NOT SCORED
need three doses of HPV vaccine. The second dose should be administered 1-2 months after the first dose, and the third dose should be administered 6 months after the first does. Adolescents aged 9 through 14 years who have already received the 2 doses of HPV vaccine less than 5 months apart will require a third dose. Three doses are recommended for people with weakened immune systems aged 9 to 26 years.				
Assessed Immunizations Up-to-date Based on date of service (DOS) **Note:** If DOS is not during flu season, then missing flu vaccine cannot be included in the assessment	1. All needed immunizations given <u>on DOS</u> per age requirement and immunization schedule – including flu vaccine if DOS is during flu season; or 2. For initial well child physical only – immunization record requested <u>on DOS</u>; or 3. Parent refusal of immunizations	1. For initial physical only "UTD per parent or guardian" noted in chart but no noted follow-up to obtain record of past immunizations; or 2. Not all needed vaccines given on DOS – including flu	1. Missed opportunity – did not give any immunizations on DOS to bring immunizations up-to-date per schedule; or 2. Records requested on subsequent physical (not initial) but no immunization	

	documented in the record; or 4. Vaccine shortage documented by practice	vaccine if DOS was during flu season	record after 1 year; or 3. Vaccines ordered but not administered	

Note: For children with Immunization delays, always refer to the "Catch-Up" schedule of the Maryland Department of Health Recommended Childhood and Adolescent Immunization Schedule to determine whether catch-up vaccines were administered according to schedule.

Combination Vaccines				
Name	**Vaccine(s)**	**Manufacturer**	**Route**	**Comments**
Pediarix	DTaP/IPV/HepB	GlaxoSmithKline	IM	Approved for doses 2, 4, 6 months (through 6 years of age). Not for boosters.
Kinrix	DTaP/IPV	GlaxoSmithKline	IM	Use is limited to 5th dose of DTaP and the 4th dose of IPV at 4-6 years.
Pentacel	DTap/Hib/IPV	Sanofi	IM	Given at 2, 4, 6 and 15 months.
Twinrix	HepA/HepB	GlaxoSmithKline	IM	Pediatric dose of HepA and adult dose of HepB. Minimum age = 18 years.
ProQuad	MMR/Varicella	Merck	SC	Measles, mumps, rubella, varicella.
Quadracel	DTaP/IPV	Sanofi	IM	Approved for age group 4-6 years old.

Component V: Health Education/Anticipatory Guidance				
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**
Documented age-appropriate Anticipatory Guidance	1. Practice uses standardized written and/or audiovisual materials that are routinely given and/or viewed at specific ages and documents "discussed with	1. Standardized written and/or audiovisual materials available but no documentation in chart regarding	1. No age-appropriate anticipatory guidance documented in chart at time of visit	

	parent/child" in the chart; or 2. "Health education/anticipatory guidance given" or "handouts given" documented; or 3. At least 3 anticipatory guidance items or 2 major topics are documented in the chart	discussion with parent or child		
Documented Health Education/Referral for Identified Problems/Tests Based on date of service **Note:** Does not include immunization missed opportunities ***Note:*** *Specify any problems not addressed by the PCP in the nurse's notes*	1. Health education/anticipatory guidance for each identified problem documented in chart; or 2. No problems identified by provider or parent; or 3. Follow-up and/or referral for specialty services for abnormal findings (including abnormal test results after "at risk" or "positive" assessments) noted in the record	1. Some but not all problems addressed by provider	1. Identified problems not addressed; or 2. Parental concern not addressed; or 3. Reviewer-identified problem not addressed or documented; or 4. Abnormal findings but no follow-up counseling and/or referral	
Documented Referral to the Dentist **Note:** Required from 1 year of age and annually thereafter	1. Routine dental visit advised and documented; or 2. Dental services noted within the past year	1. Dental education provided but no documented referral or notation of dental care services received by child within past year	1. No documented dental education or dental referral	
ELEMENT	**COMPLETE**	**INCOMPLETE**	**MISSING**	**NOT SCORED**

Specified Requirements for Return Visit ***Note:*** *Based on MD Schedule of Preventive Health Care*	1. Routine visit documented by age or interval on any of the following: encounter sheet, progress note, practice billing form or appointment system; or 2. Patient returned at appropriate interval per Schedule	1. Return "PRN"; or 2. "Return:" or "Next Appointment:" checked, but no date for return is specified; or 3. F/u appt for identified problem but not for preventive care	1. No documented return visit by date, date, or interval	

Appendix 5. – Systems Performance Review Standards for CY 2019

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.0	Systematic Process of Quality Assessment and Improvement – The QAP objectively and systematically monitors and evaluates the QOC and services to enrollees, through QOC studies and related activities, and pursues opportunities for improvement on an ongoing basis.			
1.1	The QAP ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population. a. The monitoring and evaluation of care reflects the population served by the MCO in terms of age, disease categories, and special risk status. b. The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.	The MCO demonstrates the ability to capture and analyze data that describe the demographic, health status, and utilization patterns of the enrolled population. The MCO documents processes used to prioritize problems and develop a time frame for QAP studies and projects.	QA Plan Policies & Procedures Data Analysis Enrollee Profiles (demographic; medical; pharmacy; and utilization data) QAC Meeting Minutes QA Timeline/Work Plan Outreach Plan	42 CFR § 438.330 42 CFR § 438.330(b)(4) COMAR 10.67.04.03
1.2	The QAP's written guidelines for the MCO's QOC studies and related activities require the use of quality indicators. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.	QOC study designs or project plan contain indicators based on sound clinical evidence or guidelines. The methodology and frequency of data collection will be evaluated to determine if they are sufficient to detect change.	QA Plan Policies & Procedures QOC Study Designs QOC Project Plans Quality Indicators Data Analysis	42 CFR § 438.330 42 CFR § 438.330(c) COMAR 10.67.04

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.3	The QAP has written guidelines for its QOC studies and related activities must include the use of clinical practice guidelines. a. Deleted in CY 2018. b. Clinical practice guidelines are based on evidence based practices or professional standards of practice and are developed or reviewed by MCO providers. c. The guidelines focus on the process and outcomes of health care delivery and access to care. d. A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs. e. The guidelines are included in the provider manuals or disseminated to the providers (electronically or faxed) as they are adopted. f. There are guidelines to address preventive health services for children and adults. g. The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.	There must be a comprehensive set of guidelines that address preventive care and the range of the populations enrolled in the MCO. Clinical practice guidelines provide the basis for QOC studies and related QA activities. There is evidence that these guidelines are based on reasonable evidence based practice and have been developed or reviewed by plan providers. The guidelines in use allow for the assessment of the process and outcomes of care. The MCO must have a mechanism in place for reviewing the guidelines at least every two years and updating them as appropriate. There must be evidence that the MCO disseminated guidelines to providers. The QAP has written guidelines to evaluate the QOC provided. Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical guidelines.	QA Plan Policies & Procedures Practice Guidelines Proof of Guidelines Disseminated to Providers Clinical Care Standards QOC Study Designs QOC Study Tools QOC Project Plans Quality Indicators Data Analysis	42 CFR § 438.236

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for UM decisions, enrollee education, and coverage of services.			
1.4	The QAP has written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. a. The QAP has written guidelines to evaluate the QOC provided by the MCO's providers. Appropriate clinicians monitor and evaluate quality through review of individual cases and through studies analyzing patterns of clinical care. c. Multidisciplinary teams are used to analyze, identify, and address systems issues. d. Clinical and related service areas requiring improvements are identified through activities described in a. and b. above.	The QA Plan and/or related documents describe the methodology for monitoring the quality of care provided by the MCO's providers. This may be through study of clinical care and services through individual case review, provider utilization studies, and practice pattern analysis. The composition of the team is described in the QA Plan and/or related documents. There is evidence that through these activities those areas requiring improvement are identified and acted upon.	QA Plan Data Analysis Policies & Procedures QA/QIC Meeting Minutes QA/QIC Membership QA/QIC Attendance Records	42 CFR § 438.330
1.5	The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The	The QA Plan specifies the process for identifying problems and taking appropriate corrective actions. Documentation must be provided to ensure that policies and procedures are in place that support the process and address all components of	QA Plan Policies & Procedures Data Analysis Provider Feedback CAPs	HCQIS II.E.1-7 COMAR 10.67.04

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	remedial/corrective action procedures specifically include: a. Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action. b. The individual(s) or department(s) responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the appropriate health professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff (as appropriate).	this element. This would include the identification, development, implementation and monitoring of CAPs.		
1.6	Deleted in CY 2017 SPR.			
1.7	The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and	The QA Plan describes the method to be used to assure that the QAP is routinely reviewed to assess its scope and content.	QA Plan Policies and Procedures QAC Meeting Minutes QOC Studies QAP Annual Report	42 CFR § 438.330

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	effectiveness of the QAP. a. The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis. b. There is evidence that QA activities are assessed to determine if they have contributed to improvements in the care and services delivered to enrollees.	Documentation must be provided to substantiate that QA activities have resulted in improvements to care. And if not, what is being done to address areas of opportunity for improvement. QOC study data, analysis, reports and findings may support these improvements.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.8	A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include: a. QA studies and other activities undertaken, results, and subsequent actions. b. Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results. c. Analysis of aggregate data on utilization and quality of services rendered. d. Demonstrated improvements in quality.	The annual report on the QAP must include all required components. Note: Element 2.1 requires this report to be reviewed and approved by the governing body to assess the QAP's continuity, effectiveness, and current acceptability.	Annual QAP Evaluation Report QAC Meeting Minutes	42 CFR § 438.330(b)(2)

	e. Areas of deficiency. f. Recommendations for improvement to be included in the subsequent year's QA Work Plan. g. An evaluation of the overall effectiveness of the QAP.			
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.	QAP Organizational Chart	42 CFR § 438.330
1.10	The MCO must have a Disaster Recovery Plan that is updated on an annual basis.	The MCO and its subcontractor(s) shall have robust contingency and disaster recovery plans in place to ensure that the services provided will be maintained in the event of disruption to the MCO/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.	Disaster Recovery Plan Evidence that subcontractor disaster recovery plans are in place.	COMAR 10.67.04.15

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
2.0	Accountability to the Governing Body – The governing body of the MCO is the BOD or, where the Board's participation with the QI issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care. This standard will be reviewed until the MCO attains 100% compliance.			
2.1	There is documentation that the governing body has oversight of the QAP and approves the annual	The governing body is the BOD or the designated entity of senior management that has accountability and	QA Plan MCO Organizational Chart QA Organizational Chart Governing Body Meeting Minutes	HCQIS III.A

	QA Plan/Description and QA Work Plan.	oversight of the operations of the MCO, including but not limited to the QAP. The QA Plan/Description must specify that the governing body has oversight of the QAP. The governing body meeting minutes must reflect review and approval of the annual QA Plan/Description and the annual QA Work Plan.		
2.2	The governing body formally designates an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide oversight as a committee.	Documentation must be provided to indicate what committee or body the governing body has designated as the entity accountable for oversight of QA activities. Note: When the BOD or the designated entity of senior management does not choose to provide direct oversight of the day-to-day operations of the QAP, it must formally designate in writing a committee or other entity to provide such oversight. For example, this may be the MCO's Quality Committee. However, the governing body must continue to perform all of the responsibilities noted in Standard 2.0.	Governing Body Meeting Minutes QA Plan QAC Meeting Minutes QA Organizational Chart	HCQIS III.B
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	There must be evidence that the governing body receives written reports from the QAC. Reporting to the governing body should occur according to the time frames	Governing Body Meeting Minutes QA Plan	HCQIS III.C

		documented in the QA Plan (e.g., monthly, quarterly, etc.).		
2.4	The governing body formally reviews, at least annually, a written report on the QAP Evaluation.	There must be evidence in the governing body meeting minutes that this document was reviewed and approved by the governing body.	QAP Annual Evaluation Report Governing Body Meeting Minutes	HCQIS III.D
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate review of findings and issues of concern within the MCO.	The governing body receives regular written reports from the QAP delineating actions taken and improvements made (Element 2.3). As a result, the governing body takes action and provides follow-up when appropriate. These activities are documented in the minutes of the meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the QAP.	QA Plan Governing Body Meeting Minutes QAC Meeting Minutes	HCQIS III.E
2.6	Deleted in CY 2019.			
2.7	The governing body is active in UM activities. The governing body meeting minutes reflect ongoing reporting of: UM activities and findings, and Evaluation of UM progress.	The UM Plan provides a clear definition of the overall authority and responsibility of the governing body.	Governing Body Meeting Minutes UR Plan	HCQIS XIII

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
3.0	Oversight of Delegated Entities and Subcontractors – The MCO remains accountable for all functions, even if certain functions are delegated to other entities.			
3.1	The MCO must ensure that delegates have detailed agreements and	Delegates are subcontractors that administer a critical	Delegation Contract Delegation Policies & Procedures	HCQIS VIIL A

	are notified of the grievance and appeal system. The MCO must ensure that there is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.	benefit on behalf of the MCO that impacts members directly (e.g., dental, vision, claims, UM, pharmacy). Subcontractors are individuals or entities that have a contract with an MCO that relate directly or indirectly to the performance of the MOC's obligations under its contract with the state related to Medicaid (e.g., contractors providing outreach services, call center activities, or mobile laboratory vendors). Vendors are subcontractors that administer a function that does not directly impact member services or benefits (e.g. mail room, print services, janitorial services). The contract for delegated activities contains all items listed in component a. The MCO must provide evidence that it has provided information about the grievance and appeal system to all delegates and subcontractors. For new delegates, evidence must be provided at the time that they entered into a contract with the MCO. For existing delegates, the		COMAR 10.67.04.17A

		MCO must provide evidence of an amendment to the agreement with the grievance and appeal system information or documentation it has shared the information with the delegate, and the delegate's acknowledgement of receipt.		
3.2	The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the QOC being provided.	The MCO has policies and procedures in place to monitor and evaluate the delegated functions and for verifying the care provided.	Delegation Contract Delegation Policies & Procedures Documentation of Monitoring Activities	HCQIS VIIL B COMAR 10.67.04.17.D
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including: Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. Review and approval of claims payment activities at least semi-annually, where applicable. Review and approval of the delegated entities'	There is evidence that an appropriate committee or body within the MCO makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring according to the MCO's internal policies and procedures and/or the terms set forth in the delegate's contract. The MCO must provide evidence of items a. through e.	Delegation Contract Delegation Policies & Procedures Documentation of Monitoring Activities Delegation Committee Meeting Minutes Delegated Entities' Complaints, Grievances, and Appeals Reports, where applicable Delegated Entities' Claims Payment Monitoring Reports, where applicable Delegated Entities' Utilization Activity Reports, where applicable	HCQIS VI.C 42 CFR § 438.230 (a & b) COMAR 10.67.04.17.D COMAR 31.10.11 COMAR 31.10.23.01 Ins. Art. § 15-1004 Ins. Art. § 15-1005

	UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable. Review and approval of over and under utilization reports, at least semi-annually, where applicable.			
3.4	The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.	When the MCO terminates a subcontract, the MCO shall provide the Department with written notice regarding the termination that complies with the requirements of COMAR 10.09.65.17B(5).	Subcontractor Policies and Procedures Subcontractor Termination Notices	COMAR 10.67.04.17B(5)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.0	Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services. This standard will be reviewed until the MCO attains 100% compliance.			
4.1	The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. a. The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process.	The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing. The Credentialing Plan must designate the peer review body that has the authority to make recommendations regarding credentialing decisions and must identify	Credentialing Plan Credentialing Process in QA Plan Governing Body Meeting Minutes Credentialing Policies & Procedures	HCQIS IX A-D Ins. Art. § 15-112 (a)(4)(ii)(9) Ins. Art. § 15-112 (d) COMAR 10.67.04.02M COMAR 10.67.04.17

	b. The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions. c. The Credentialing Plan must identify the practitioners who fall under its scope of authority and action. d. The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d).	the practitioners who fall under its authority. Within 30 days of receipt of a completed application, the MCO shall send to the provider at the address listed in the application written notice of the MCO's: intent to continue to process the provider's application to obtain necessary credentialing information. rejection of the provider for participation in the MCO's provider panel. If the MCO provides notice to the provider of its intent to continue to process the providers application, the MCO, within 120 days after the date the notice is provided, shall: Accept or reject the provider for participation on the MCO's provider panel. Send written notice of the acceptance or rejection to the provider at the address on the application. After the MCO receives the completed application, the MCO is subject to the aforementioned time frames for completed application processing. When an "online credentialing system" is		

		utilized by the MCO the following applies: The MCO is required to track the date of the application i.e. query the online credentialing system so that dates of credentialing can be calculated. The "10-Day Letter" is not applicable since the entire application must be completed prior to exiting the application. The "30-Day Letter" still applies with the above mentioned timeframes. If an MCO does not accept applications through an "online credentialing system", notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received that the application is complete.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.2	There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes: a. Written policies and procedures for the suspension, reduction, or termination of practitioner privileges.	There are policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There is evidence that these policies and procedures have been implemented. The policies and procedures must identify the mechanism for reporting serious quality	Credentialing Plan Recredentialing Plan Credentialing Policies & Procedures Provider Appeal Policy & Procedure Provider Appeals Files Facility Site Reviews (completed forms/files)	HCQIS IX H-J

	b. A documented process for, and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. c. Deleted in CY 2019.	deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place.		
4.3	If the MCO delegates credentialing/ recredentialing activities, the following must be present: a. A written description of the delegated activities. b. A description of the delegate's accountability for designated activities. c. Evidence that the delegate accomplished the credentialing activities.	The contract for delegated services includes a description of the delegated activities and the delegate's accountability for designated activities. The delegate provides reports to the MCO according to the contract requirements.	Delegation Contract Delegate Progress Reports to the MCO MCO Monitoring/Auditing Documents	HCQIS IX G

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.4	The credentialing process must be ongoing and current. At a minimum, the credentialing process must include: A review of a current valid license to practice. A review of a valid DEA or CDS certificate, if applicable. A review of graduation from medical/ancillary (NP, PT, OT, SLP etc.) school and completed residency or post-graduate training, as applicable. A review of work history. A review of a professional and liability claims history. A review of current adequate malpractice insurance according to the MCO's policy. Deleted as of the CY 2017 SPR. A review of EPSDT certification. Adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements. Adherence to the time frames set forth in the MCO's policies for communication with providers regarding provider applications within the time frames specified in Insurance	The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the information required in components a-h for the credentialing process. Note: (h) is applicable to those PCPs who deliver preventive health care services to enrollees less than 21 years of age. The reviewer will assess the MCO's methodology for verifying whether PCPs in the MCO's network that see patients under age 21 are EPSDT certified.	Credentialing Plan Credentialing Policies & Procedures Sample Credentialing Records Written correspondence to providers.	HCQIS IX E.1-7 42 CFR § 438.214 (c-e) COMAR 10.67.04.02.N Ins. Art. § 15-112 (a)(4)(ii)(9) Ins. Art. § 15-112 (d)

	Article Section 15-112(d).			
4.5	The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include: Any revocation or suspension of a State license or a DEA/BNDD number. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records). Any sanctions imposed by Medicare and/or Medicaid. Information about the practitioner from the NPDB and the MBP.	The credentialing plan and policies and procedures require that the MCO request information required in components a-d from recognized monitoring organizations.	Credentialing Plan Credentialing Policies & Procedures Sample Credentialing Records Credentialing Committee Meeting Minutes	HCQIS IX E.8-12

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.6	The credentialing application includes the following: a. The use of illegal drugs. b. Any history of loss of license. c. Any history of loss or limitation of privileges or disciplinary activity. d. Attestation to the correctness and completeness of the application.	The credentialing plan and policies and procedures describe the application process. This process includes the requirement that the applicant must provide a statement that includes components a-d. There must be evidence in the credentialing files that this statement is completed. Type of credentialing application must be reviewed and in compliance with MIA regulatory requirements noted.	Credentialing Plan Credentialing Policies & Procedures Sample Credentialing Records Completed Application Completed Uniform Credentialing Form	HCQIS IX E.13.a-e COMAR 31.10.26.03

4.7	There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.	The credentialing plan and policies and procedures must require an initial visit to each potential primary care practitioner's office. There must be documentation that a review of the site includes both an evaluation of ADA compliance and medical record keeping, and that these practices are in conformance with the MCO's standards. Such standards should consider: Handicapped designated parking clearly marked and close to the entrance. Ramps for wheelchair access. Door openings to the practice and restroom and hallways should facilitate access for disabled individuals. Elevator availability for practices above ground level.	Credentialing Plan Credentialing Policies & Procedures Site Visit Tool Sample Completed Site Visit Tools Sample Credentialing Records Applicable Reports of On-site Visits Credentialing Committee Meeting Minutes	HCQIS IX E.14 COMAR 10.67.04.02 H (1) 28 CFR Chapter 1, Part 36

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.8	There is evidence that recredentialing is performed at least every three years and: a. Includes a review of information from the NPDB. b. Deleted in CY 2019. c. Includes all items contained in element 4.4 a–h, except 4.4 d (work history). d. Includes all items contained in 4.6 a–d. e. Meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.	The credentialing plan and policies and procedures indicate that recredentialing is performed at least every three years. The recredentialing process requires a review of components contained in a-d. There is evidence in individual provider credentialing files that this has occurred. This information is used to decide whether or not to renew the participating physician agreement.	Credentialing Plan Recredentialing Policies & Procedures Sample Credentialing Records Credentialing Committee Meeting Minutes	HCQIS IX F.1-2 COMAR 10.67.04.02.N Ins. Art. § 15-112 (d)
4.9	There is evidence that the recredentialing process includes a review of the following: Enrollee complaints/grievances. Results of quality reviews. Deleted in CY 2018. Office site compliance with ADA standards, if applicable.	There is evidence in provider recredentialing records that complaints, grievances, and the results of quality reviews were reviewed prior to the MCO's recredentialing of providers. There is a process in place to re-assess provider site ADA compliance when: provider relocates to a site that has not previously been evaluated and approved as being ADA compliant, or there is evidence of ADA non-compliance issues with a particular site of care delivery.	Credentialing Plan Recredentialing Policies & Procedures Sample Recredentialing Records	HCQIS IX F.3 a – e
4.10	The MCO must have policies and procedures	Policies and procedures should be directed at	Credentialing Plan	42 CFR § 438.214

	regarding the selection and retention of providers. The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program. The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.	ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, ensuring that providers are retained within the Medicaid network.	Credentialing Policies and Procedures	42 CFR § 438.207

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.11	The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a	The MCO must include in the notification: An explanation of the EPSDT preventive screening services to which an enrollee is entitled according to the EPSDT periodicity schedule (only a summary is necessary if the periodicity schedule was included in the MCO's welcome packet); Importance of accessing the EPSDT preventive screening services; and Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services.	Policies and Procedures Letters to Parents/Guardians	COMAR 10.67.04.05

	certified EPSDT PCP if desired.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.12	The MCO must have written policies and procedures for notifying the Department of provider terminations.	MCO must be compliant with the following COMAR 10.09.65.17B(4) requirements for notifying and reporting provider terminations: When an MCO and provider terminate their contract the MCO shall provide the Department with a written notice regarding the termination. If the MCO is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided 90 days before the effective date of the termination. If the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider. If 50 to 99 enrollees are affected, the notice shall contain the: Date of termination; Name or names of providers or subcontractors terminating; Number of enrollees affected; and MCO's plan for transitioning enrollees to other providers.	Network Provider Termination Policies and Procedures Network Provider Termination Notices to MDH Examples of completed MDH required forms	COMAR 10.67.04.17 B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		If more than 99 enrollees are affected, the MCO shall provide the Department with a Department-approved termination survey. In determining the number of enrollees affected under §B(4)(d) and (e) of this regulation, the MCO shall consider: For PCPs, the number of enrollees assigned to the PCP; and For all other providers, the number of enrollees who are in active treatment or who have had an encounter with the provider in the previous 12 months.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.0	Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.			
5.1	The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.09.71.02 and 10.09.71.04. a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.09.71. b. The system requires documentation of the substance of the	Time frames for resolving grievances in the policy and procedure must be in accordance with the following: Emergency medically related grievances not > 24 hours. Non-emergency medically related grievances not > 5 days. Administrative grievances not > 30 days. The policy and procedures must describe what types of information will be collected when grievances	Grievance Policies & Procedures Grievance Form Grievance Logs Grievance Reports Grievances Files QAC/QIC Meeting Minutes CAB Meeting Minutes Quarterly Complaint/Grievance/ Appeal Reports Sample Grievance Letters to Members	COMAR 10.67.09.05 42 CFR § 438.402 (a & b) 42 CFR § 438.406 (a & b) 42 CFR § 438.408 (a-f)COMAR 10.67.09.04

	grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure. d. The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in CY 2018. There is complete documentation of the substance of the grievances and steps taken in the case record. The MCO adheres to regulatory time frames for written acknowledgment and written resolution of all grievances, even if the resolution was previously provided verbally. h. The MCO ensures that written resolution letters describe the grievance and the resolution in easy to understand language.	are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how an enrollee can get assistance from the MCO in completing the form. The MCO must have a documented procedure for written notification of the MCO's determination: To the enrollee who filed the grievance To those individuals and entities required to be notified of the grievance To the Department's complaint unit for complaints referred to the MCO by the Department's complaint unit or ombudsman program If closing the grievance case due to not being able to contact the member via phone, the MCO must notify the member in writing that their grievance is being closed. The policies and procedures must describe the complete process from the registration through resolution of grievances. The policies and procedures must allow participation by the provider or an ombudsman, if appropriate, and must ensure the participation of		

		individuals within the MCO who have authority to require corrective action. A sample of selected grievances is reviewed to assure that the process is complete and is being followed. The policies and procedures describe the process to be used for data collection and analysis. This must include time frames for collection and reporting. (e.g., collected and analyzed quarterly, reported to the QAC quarterly). The policies and procedures must include the notification of results to the provider and the QACs as required by COMAR. If problems are identified, the reviewer will track the progress of problem resolution.		
5.2	The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.09.66.01C.	COMAR 10.09.66.01C states that all written materials must: Use language and a format that is easily understood; Be available in alternative formats and through the provision of auxiliary aids and services Be available in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with	Enrollee Informational Materials	COMAR 10.67.04.02.H COMAR 10.67.05.01 42 CFR § 438.10 42 CFR § 438.206 (c)(2)

		disabilities or limited English proficiency. Enrollee information including, but not limited to, enrollee handbook, newsletters, and health education materials are written at the appropriate reading comprehension level for the Medicaid population. The SMOG formula or the Flesch-Kincaid Grade Level Index will be applied to determine readability.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO: a. Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data. b. Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO. c. Must hold confidential all information obtained by its personnel about enrollees related to their	The policies and procedures address all required components described in a-e. The MCO must provide evidence that these policies and procedures have been implemented. The MCO must provide documentation to demonstrate that it ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information.	Medical Records Policies & Procedures Confidentiality Policies & Procedures Sample Provider Contracts Sample Provider Site Visit Evaluation Tool Credentialing Policies & Procedures Tools Related to Assessing Confidentiality of Patient Medical Records Sample of MCO Employee Confidentiality Statement Signed MCO Employee Confidentiality Statements Sample Vendor Contracts	HCQIS X.1 42 CFR § 438.100 (d) 42 CFR § 438.224 HIPAA Health-General §§ 4-301

	care and shall not divulge it without the enrollee's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual. d. Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner. e. May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.4	The MCO has written policies regarding the appropriate treatment of minors.	The MCO has a written policy addressing the appropriate treatment of minors. This policy must address the minor's right to receive treatment without parental consent in cases of sexual abuse, rape, family planning, and sexually transmitted diseases.	Treatment of Minors Policy	HCQIS X.J Health General 20-102
5.5	As a result of the enrollee satisfaction surveys, the MCO: Identifies and investigates sources of dissatisfaction. Implements steps to follow up on the findings. Informs practitioners and providers of assessment results. Reevaluates the effects of b. above at least quarterly.	There is a process in place for identifying sources of dissatisfaction. The MCO must have mechanisms in place to identify problems, develop plans to address problems, and provide follow-up. There must be documentation (e.g. meeting minutes, CAPs) to demonstrate that policies and procedures are in place and are being followed. There is a mechanism in place to provide survey information to providers as a group, and to an individual provider(s) if warranted.	Patient Satisfaction Evaluation Policies and Procedures Patient Satisfaction Evaluation Tool Patient Satisfaction Survey Data Analysis Corrective Action Plans Appropriate Committee Meeting Minutes	
Standard	**Description**	**Review Guidelines**	**Documents to be Reviewed**	**Cite(s) and References**
5.6	The MCO has systems in place to assure that new enrollees receive required information within established time frames. a. Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames	Policies and procedures address the content of new enrollee information packets and time frames for receipt of the packets. At a minimum, new enrollee information packets contain: Enrollee ID card Enrollee handbook Provider Directory	Enrollee Handbook Enrollee Notices Sample New Enrollee Information Packet New Enrollee Policies & Procedures Committee Meeting Minutes ID Card Fulfillment Reports	COMAR 10.67.05.02 COMAR 10.67.02. Ins. Art. § 15-140 42 CFR 438.10 COMAR 10.67.04.

	for sending such information to the enrollee. b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO's ID card. c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution. The MCO includes the Continuity of Health Care Notice in the new enrollee packet. The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	The MCO uses State-developed model enrollee handbooks and notices. New enrollee information packets are provided to new enrollees within 10 calendar days of MDH's notification to the MCO of enrollment. The packet includes the Continuity of Health Care Notice that is required by § 15-140(f) of the Insurance Article. The MCO has written procedures that track and monitors timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through committee or the MCO's administrative structure. There is a documented process for newborn enrollment that includes time frames. The MCO has a documented internal mechanism for processing and follow-up on the Daily MCO Newborn Enrollment Report from the Department.	ID Card Fulfillment Tracking and Trending Analysis	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.7	The MCO must have an active Consumer Advisory Board (CAB).	An MCO shall establish a CAB to facilitate the receipt of input from enrollees. The CAB	Policies and Procedures Committee Charter CAB Meeting Minutes CAB Annual Summary	COMAR 10.67.04.12

	The MCO's CAB membership must reflect the special needs population requirements. The CAB must meet at least six times a year. The MCO must have a mechanism for tracking enrollee feedback from the meetings.	membership shall consist of enrollees and enrollees' family members, guardians, or caregivers. It is to be comprised of no less than 1/3 representation from the MCO's special needs populations, or their representatives. Pursuant to regulation, the CAB shall annually report its activities and recommendations to the MDH. The CAB Annual Report will, at a minimum, include the following information: CAB Charter or P&P Mission/Vision Statement for the CAB Goals for the CAB Structure of and member composition of the CAB Dates, times, and locations for each CAB meeting Summary of topics/issues discussed Member feedback/concerns Accomplishments/Resolutions Opportunities for Improvement/Follow-up		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights. Materials distributed by the MCO to the enrollee will include a	The MCO shall notify enrollees of the following services and make them available free of charge to the enrollee: Written materials in the prevalent non-English languages identified by the State;	Enrollee Handbook Provider Directory Enrollee Information/ Material Screen Shot of the MCO Website Pictures of Notices and Taglines posted at member events	45 CFR § 92.7 45 CFR § 92.8 42 CFR § 438.10 COMAR 10.67.05.01

	nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page. Notices and Taglines must be posted in significant communications and publications. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. MCO's electronic information provided to members must meet requirements set forth in COMAR.	Written materials in alternative formats; Oral interpretation services in all non-English languages; and Auxiliary aids and services, such as: Teletypewriter/Telecommunication Device for the Deaf (TTY/TTD); and American Sign Language. The MCO shall include taglines with its written materials that: Explain the availability of written translation or oral interpretation to understand the information provided; and Provide the toll-free and TTY/TTD telephone number of the MCO's customer service unit. MCOs must take steps to notify enrollees and prospective enrollees about their rights under Section 1557 of the ACA. Specifically, MCOs must post a nondiscrimination Notice in English and in at least the top 15 non-English languages spoken by the individuals with limited English proficiency of the relevant State or States. MCOs may combine the content of the Notice with other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Small-size material (trifold	Websites Online Directories	

		brochures) must have statement and taglines in at least the top 2 non-English languages. MCOs may use the Sample "Discrimination is Against the Law" statement to meet this requirement. The Notice and Taglines must be posted in a conspicuously-visible font size in a conspicuous location of covered entity websites accessible from the home page, in significant communications and significant publications, and, where appropriate, in conspicuous physical locations where the entity interacts with the public. This applies to, but is not limited to: Marketing materials, enrollee communications related to health coverage, benefits, and prescription drug coverage, provider/pharmacy directories, formularies, enrollment forms, summary of benefits, and appeal and grievance notices. COMAR 10.09.66.01.D states that if the MCO provides enrollee information electronically (provider directory, EOB, member handbook), the following requirements must be met:		

		The format is readily accessible; The information is placed in a location on the MCO's website that is prominent and readily accessible; The information is provided in an electronic form which can be electronically retained and printed; The information is consistent with the content and language requirements of this section; The enrollee is informed that the information is available in paper form without charge upon request; and Should the enrollee request it, the MCO provides the information in paper form within 5 business days. MCOs should be prepared to provide evidence of materials referring enrollees to online information that advises them how to request printed material free of charge; evidence that the online information provided is downloadable and printable; and information/reports that are uploaded to the MCO website should be 508c accessible.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.9	The MCO must maintain written policies and	The MCO must have written policies and procedures for advance	Policies and Procedures Member Handbook Enrollee Notices	42 CFR § 422.128

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	procedures for advance directives. The MCO must educate staff regarding advance directives policies and procedures. The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618). The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	directives. Advance directives are written instructions, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. MCOs must educate staff on advance directives. Staff should include clinical staff, case management, member services, and outreach staff that would interact with members and advance directives. Additionally, network management staff should be educated since they have contact with the provider network. MCO must provide examples of completed staff training such as signed attestations and rosters of staff showing dates of annual training completed.	Staff Notices Evidence of staff training	42 CFR § 438.3(j)(1) 42 CFR § 489.100 Hlth Gen Art §5-601-618 COMAR 10.67.04.02
5.10	MCO must comply with the marketing requirements of COMAR 10.09.65.23. An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO	The MCO's marketing policies and procedures complies with the requirements of COMAR 10.09.65.23. An MCO may not have face-to-face or telephone	Marketing Policies and Procedures Marketing Requests and Approvals from the Department	42 CFR § 438.104 COMAR 10.67.04.23

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	unless contact is authorized by the Department or contact is initiated by the recipient. An MCO cannot engage in marketing activities without prior approval of the Department. Deleted in CY 2018.	contact with a recipient, or otherwise solicit a recipient who is not an enrollee of the MCO, unless authorized by the Department or the recipient initiates the contact. Subject to prior approval by the Department, an MCO may engage in marketing activities designed to make recipients aware of their availability, as well as any special services they offer. These marketing activities may involve campaigns using but not limited to: Television; Radio; Newspaper; Informational booths at public events; Billboards and other public displays; Addressee-blind informational mailings, but only when mailed to the MCO's entire service area; Magazines; Airborne marketing displays; or Public conveyances.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
6.0	Availability and Accessibility – The MCO has established measurable standards for access and availability.			
6.1	The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and	The MCO has established access and availability standards that comply with HCQIS and COMAR requirements and demonstrates that these	Access and Availability Standards Access and Availability Policies & Procedures Provider Manual Newsletters	HCQIS XI COMAR 10.67.05.03-08

	availability of health care services. a. The MCO has developed and disseminated written access and availability standards. The MCO has processes in place to monitor performance against its access and availability standards at least quarterly. The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance. The MCO has documented review of the Enrollee Services Call Center performance.	standards have been disseminated to providers. These standards must include: routine appointments urgent appointments emergency care/services telephone appointments advice enrollee service lines outreach clinical and pharmacy access The MCO must monitor against the above standards. The following should be included to ensure compliance with standards: Quarterly calls be conducted to a sample of providers to ensure compliance with all access and availability standards including but not limited to the validation of provider directory information, compliance with appointment availability, and after hour requirements. Quarterly survey results should be reviewed, reported, and trended by the MCO. Providers failing the survey for not meeting access standards will be provided education and included in a survey within the next 6th months to ensure compliance. If the provider fails the following survey, they will be placed on a	Monitoring and Evaluation Processes Committee Meeting Minutes Monitoring Reports Performance Trends Evidence of Quarterly Monitoring of Access and Availability Standards	42 CFR §438.206(c)(1) 42 CFR §438.210 COMAR 10.67.05.07.B(2) 42 CFR §438.68(c)(1)(vii) 42 CFR §438.68(c)(1)(viii) 42 CFR § 438.206(c)(2) 42 CFR § 438.206(c)(3) CMS's Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf

		Corrective Action Plan by the MCO. The MCO has also established policies and procedures for the operations of its internal customer/enrollee services. Performance standards have been developed, such as telephone answering time, wait time, abandon call rates, and time frames for response to enrollees' inquiries. Such standards are measured for performance and identification of issues that affect enrollee services and are reported through established channels, such as committees.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
6.2	The MCO has a list of providers that are currently accepting new enrollees. a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population. At the time of enrollment, enrollees are provided with information about the MCO's providers. The MCO has a methodology in place to assess and monitor the network needs of its	The MCO must conduct annual geo mapping to calculate average distance to ensure compliance with geographic access requirements. Specific network capacity and geographic access requirements are defined in COMAR 10.09.66.05.B and COMAR 10.09.66.06.B-D. Some of these are listed below: Enrollee to physician ratio for local access area = 200:1	Provider Directory Provider Manual New Enrollee Packet New Enrollee Orientation Materials Availability & Access Standards Access and Availability Policies & Procedures Monitoring Methodology Monitoring Reports Committee Meeting Minutes Top Ten Diagnoses for all Care Settings Enrollee Complaint Reports Documentation of any CAPs	HCQIS XI COMAR 10.67.05.02.C COMAR 10.67.05.05.B COMAR 10.67.05.06.B-D COMAR 10.67.05.01.A (3)) 42 CFR § 438.206 (b)

	population, including individuals with disabilities. The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.	Travel distance (urban) - 10 mile radius Travel distance (suburban) – within 20 mile radius Travel distance (rural) - within 30-mile radius. Annually compare percentages of network providers who communicate in non-English languages most common among enrollees. As defined in COMAR, the MCO must make available a listing of individual practitioners who are the MCO's primary and specialty care providers. Information must include: Name as well as any group affiliation Street address Telephone number Website URL, as appropriate Specialty, as appropriate An indication of whether or not the provider is accepting new Medicaid patients The provider's cultural and linguistic capabilities (including American Sign Language) An indication of whether the provider has completed cultural competence training An indication of whether or not access to the provider is otherwise limited (e.g. by age of	Online Provider Directories Provider Directory Machine Readable Format and File Link to Online Provider Directory Screenshots of Online Provider Directory	42 CFR § 438.207 42 CFR § 438.10 (h) (1) (i-viii) 42 CFR § 438.10 (f) (2-6

		patient or number of enrollees the provider will serve) An indication of whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms(s) and equipment The MCO must perform a quarterly review of the number of participating providers in the plan by type, geographic location, specialty, and acceptance of new patients.		
		The directory must also include: ● A listing of the MCO's hospital providers, of both inpatient and outpatient services, in the enrollee's county with their addresses and services provided. Provider directories must be made available on the MCO's website in a machine-readable file and format. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology substantiates how the MCO determines that it		

		has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs of its population in all care settings. The methodology includes: ● A process of monitoring that has the ability to identify problem areas that are reported through the MCO's established structure. ● Follow-up activities and progress towards resolution that are evident. ● Direct access to specialists. Each MCO must have a mechanism in place to allow enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee's condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided for example, through a standing referral or an approved number of visits.		

		"An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees: In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it."		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
6.3	The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services. a. Deleted in CY 2019. b. Deleted in CY 2019. c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	Policies and procedures must be in place and address trending and analysis of wellness services. The analysis must be included in the QAP with CAPs developed as appropriate. Documentation must be provided to substantiate that time frames are adhered to and that tracking procedures are in place. The MCO has a written procedure/methodology that tracks and monitors timeliness of IHAs. Such monitoring is analyzed and if un-timeliness is	• Scheduling of IHA Policies & Procedures • IHA completion analysis • QAP	HCQIS XI COMAR 10.67.03.06 COMAR 10.67.05.03 COMAR 10.67.05.07

		identified, there is evidence of corrective action and evaluation of progress. Performance is reported through committee or the MCO's administrative structure.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.0	Utilization Review – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.			
7.1	There is a comprehensive written UR Plan. a. This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services. b. The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.	The UR Plan is comprehensive and addresses components a-c. Component 7.1(c) requires that the MCO documentation reflect that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	• UR Plan • UR Meeting Minutes • Governing Body Meeting Minutes	42 CFR § 438.236 HCQIS XII A

	c. There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.			
7.2	The UR Plan specifies criteria for UR/UM decisions. a. The criteria used to make UR/UM decisions must be based on acceptable medical practice. b. The UR Plan must describe the mechanism or process for the periodic updating of the criteria. c. The UR Plan must describe the involvement of participating providers in the review and updating of criteria. d. There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures. e. There is evidence that UR/UM staff receive annual training on the interpretation and application of	There is evidence that UR criteria are based on acceptable medical practice. The UR Plan must describe the process for reviewing and updating the criteria and for involving providers. There must be evidence that criteria are reviewed and updated per the policies and procedures. The MCO must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.	• UR Plan • Documentation of review/approval of new medical necessity criteria/updates • Policies & Procedures for Criteria Review/Revision, annual IRR assessment, and annual training on UM criteria • UR Committee Meeting Minutes • Sign-in sheets, training logs, certficates of completion of annual training on UM criteria • Documentation of annual assessment of IRR among UM staff/physicians	HCQIS XII A COMAR 10.67.04.11 S 2

	UR/UM criteria/guidelines. f. There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/UM criteria on at least an annual basis.			
7.3	The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. a. Services provided must be reviewed for over and under utilization. b. UR reports must provide the ability to identify problems and take the appropriate corrective action. c. Corrective measures implemented must be monitored.	The UR Plan describes the process to be used for detecting over and under utilization of services. UR reports and data analysis must be available and should demonstrate the ability to identify problems. There must be documentation to support that the MCO has developed, implemented, and provided follow-up of corrective actions for the identified issues.	• UR Plan • UR Policies & Procedures • Data Reports and Analysis • CAPs • UR Committee Meeting Minutes • Provider Profiles	HCQIS XI 42 CFR § 438.330 (b)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.4	The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall	MCO policies and procedures must be compliant with the requirements of COMAR 10.09.71.04. The MCO must demonstrate that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care	UR Plan UR Policies & Procedures UR Organizational Charts UM Position Descriptions UM Staffing Plan UR Committee Meeting Minutes Delegate Reports to MCO MCO Monitoring of Delegate Reports TAT Compliance Reports	HCQIS XIII.C 1-7 COMAR 10.67.09.0 42 CFR § 438.210 (c & d)

	be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. Time frames for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	professional who has appropriate clinical expertise in treating the enrollee's condition or disease. For standard preauthorization requests, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. For expedited authorization requests, the MCO shall make a preauthorization determination and provide notice in a timely manner so as not to adversely affect the health of the enrollee and no later than 72 hours after receipt if the provider indicates or the MCO determines following the standard timeframe could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. For outpatient drug preauthorization decisions, the MCO shall provide notice to approve, deny, or request additional information by		

		telephone or other telecommunication device to the requesting provider within 24 hours of request. Written notice is provided to the member with a copy to the requesting provider within 72 hours. There is an exception for the HepC drugs. The enrollee, enrollee's representative, or the MCO may request an extension of the authorization timeframe of up to 14 calendar days. If the MCO extends the authorization timeframe, the MCO must provide evidence it notified enrollees in writing of the extension and the reason, as well as enrollees' right to file a grievance if they disagree with the MCO's decision. The state specified threshold for all preauthorization review decisions is 95%. A sample of preauthorization reviews must be reviewed for compliance with state specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95%		

		and a sampling error of 5%.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.5	Adverse determination letters include a description of how to file an appeal. All adverse determination letters are written in easy to understand language. Adverse determination letters include all required components.	There must be documented policies and procedures for appeals. Such policies and procedures must comply with the requirements stated in COMAR 10.09.71.04F. The required adverse determination letter components include: Explanation of the requested care, treatment, or service. Clear, full and complete factual explanation of the reasons for the denial, reduction or termination in understandable language. Conclusive statements such as "services included under another procedure" and "not medically necessary" are not legally sufficient. Use of the phrase "nationally recognized medical standards" is acceptable; however, the exact clinical guideline reference must be included. Availability of a free copy of any guideline, code, or similar information MCO used to decide and the MCO	Enrollee Adverse Determination Letter Policies and Procedure Sample Enrollee Adverse Determination Letters Selected UR Cases	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.04F 42 CFR § 438.404 45 CFR § 92.7 45 CFR § 92.8

		contact number including TTY/TTD. Description of any additional information MCO needs for reconsideration, if appropriate from enrollee and/or provider. Statement of the availability and contact information of the MCO representative who made the decision if the enrollee's provider would like to contact him/her. The enrollee's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action. This includes a copy of the enrollee's medical record, provided free of charge. Direction to the enrollee to call the HealthChoice Help Line for assistance. The enrollee may also appeal to the MCO directly by contacting the MCO (phone # or address) within 60 days from the date of receipt. Explanation to the enrollee that if he/she is currently receiving ongoing services that are being denied or reduced, he/she may be able to continue receiving these services during the appeal process by calling		

		the MCO or the HealthChoice Help Line within 10 days from receipt of this letter. If the enrollee's appeal is denied, he/she may be required to pay for the cost of the services received during the appeal process. Statement that the enrollee may represent self or use legal counsel, a relative, a friend, or other spokesperson. An explanation that it is assumed an enrollee receives the letter 5 days after it is dated unless he/she shows evidence otherwise. There is evidence that the letter is copied to the requesting provider with copying the PCP optional. A statement explaining the availability of the expedited review process, MCO phone number and time frame for making a determination. A statement that the enrollee or their representative may request an extension of the timeframe for appeals by up to 14 calendar days. A statement of availability of the letter in other languages and alternate formats. Notice of Nondiscrimination and		

		Appeals and Grievance Rights document.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.6	The MCO must be compliant with the requirements of COMAR 10.09.71.04 pursuant to notification requirements for preauthorization denials. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State. The MCO demonstrates compliance with adverse determination notification time frames in response to preauthorization requests as specified by the State.	MCOs shall notify the enrollee and the provider in writing whenever the provider's request for preauthorization for a service is denied. Written notice of decision to deny initial services must be provided to the enrollee: within 24 hours of the expedited authorization determination, and within 72 hours of receipt of the request, and within; 72 hours for standard requests and outpatient drug decisions. For any previously authorized service, written notice to the enrollee must be provided at least 10 days prior to reducing, suspending, or terminating a covered service. The state specified threshold for all adverse determination notifications is 95%. A sample of adverse determination notifications must be reviewed for compliance with state specified timeliness by the	UR Plan UR Policies & Procedures UR Committee Meeting Minutes Selected UR Cases Enrollee Notices TAT Compliance Reports	HCQIS XIII.C 1-7 COMAR 10.67.09.04 42 CFR § 438.10 (f & g)

		MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.7	The MCO must have written policies and procedures pertaining to enrollee appeals. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.09.71.02 and COMAR 10.09.71.05. The MCO's appeals policies and procedures must	There is evidence that appeals are resolved and notification provided within the time frames established by the State. Time frames for resolving and providing notification of appeal decisions in the policy and procedure must be in accordance with the following: Expedited Appeals must be resolved within 72 hours of receipt and written	UR Organizational Charts UM Position Descriptions QM Committee Meeting Minutes Enrollee Appeals Policies & Procedures Contract Appeals Forms & Logs Appeals Reports including TAT compliance	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.05 42 CFR § 438.404 (b) 42 CFR § 438.406 (a & b) 42 CFR § 438.408 (a-f)

	include staffing safeguards to avoid conflicts of interest when reviewing appeals. The MCO must adhere to appeal timeframes. The MCO's appeal policies must include procedures for how the MCO will assist enrollees with the appeal process. Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request. Written notifications to enrollees include appeal decisions that are documented in easy to understand language.	notification of the decision provided within 24 hours. The MCO must also make reasonable efforts to provide oral notice of the decision. Standard Appeals must be resolved and written notice provided within 30 days, unless extended pursuant to 438.408 b & c. Appeals may be extended up to 14 days. The MCO must ensure that decision makers on appeal were not involved in previous levels of review or decision making, were not subordinates of decision makers involved in previous levels of decision making, and are health care professionals with clinical expertise in treating the enrollee's condition or disease. The method to collect information for review decisions is documented. A selected sample of enrollee appeals, or provider appeals submitted on behalf of the enrollee, will be reviewed to assure that the policies and procedures are being followed.	Appeal Records Enrollee Notices	
7.8	The MCO must have written policies and procedures pertaining to provider appeals. The MCO's provider appeals policies and procedures must be	Compliant with the requirements of COMAR 10.09.71.03, the MCO must have written policies and procedures for provider appeals. The state specified threshold for all provider	Provider Appeals Policies & Procedures TAT Tracking logs for monitoring compliance with written	HCQIS XIII.C 1-7 COMAR 10.67.09.03 42 CFR § 438.236

	compliant with the requirements of COMAR 10.09.71.03. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	appeal resolution is 95%. The MCO must provide evidence that it is monitoring compliance with written acknowledgment and resolution time frames through routine reports (i.e weekly., monthly or quarterly) consistent with the MCO's policies that includes the compliance percentage for each of the regulatory time frames.The MCO can include either all provider appeals or a statistically valid sample in reporting compliance. If using a sample the MCO must use a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The MCO must include in its provider complaint process at least the following elements: An appeal process which: Is available when the provider's appeal or grievance is not resolved to the provider's satisfaction; Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; Allows providers 90 business days from the date of a denial to file an initial appeal; Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal; Resolves appeals, regardless of the number of appeal	acknowledgment and written resolution of provider appeals TAT Compliance Reports for written acknowledgment and written resolution Appeal Records	

		levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO; Pays claim within 30 days of the appeal decision when a claim denial is overturned; Provides at its final level an opportunity for the provider to be heard by the MCO's chief executive officer, or the chief executive officer's designee; Provides timely written notice to the provider of the results of the internal appeal.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.9 (Formerly 7.6)	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.	The intent of this element is to provide a mechanism for enrollees and providers to offer opinions on the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues. There must be evidence these processes are in place and functioning. There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the process to evaluate the effects of the program using data on enrollee and provider satisfaction and/or other appropriate measures. Data sources must include the MCO's internal and	Enrollee & Provider Satisfaction Policies and Procedures Relating to UR Program Enrollee and Provider Satisfaction Surveys Evaluating UR Program Data Reports Evidencing Review Trending Reports Action Plans Committee Meeting Minutes	COMAR 10.67.04.03

	The MCO acts upon identified issues as a result of the review of the data.	MDH coordinated enrollee and provider satisfaction surveys. It is expected that the MCO will review results of member and provider satisfaction surveys and develop and implement action plans to address identified opportunities for improvement timely in order to have some impact on subsequent survey results.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.10 (Formerly 7.7)	The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse	"Independent review organization" means an entity that contracts with the Department to conduct independent review of managed care organizations' adverse decisions.	Complaint Resolution/IRO Policy and Procedure MCO Independent Review Organization Agreement Online Account Sample Case Record	COMAR 10.67.13.00

	medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.	The MCO's specific responsibilities under the Maryland Medicaid Managed Care Independent Review Services process are as follows and should be included in the policy and procedure: Establish an online account with the IRO and provide all required information through this account. Upload the complete case record for each medical case review request within five (5) business days of receipt of the request from the IRO. Upload any additional, case-related documentation requested by the IRO within two (2) business days of receipt of notification of a request for additional information from the IRO. Agree to pay the fixed case fee should the IRO rule against the MCO and has a process to assure IRO invoices are paid within 60 days per COMAR 10.09.86.07C(2).		

7.11 (Formerly 7.8)	The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan. The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in in regulation. The MCOs must provide evidence of implementation of the corrective managed care plan.	The MCO must have documented policies and procedures for a corrective managed care plan for abuse of pharmacy benefits consistent with COMAR 10.09.75. An MCO's corrective managed care plan shall cover enrollee abuse of medical assistance pharmacy benefits. For all pharmacy benefit abuse covered by an MCO's corrective managed care plan, the plan shall: Use the criteria as described in Regulation .01B of this regulation to determine if enrollees have abused benefits; Provide for a medical review of the alleged abuse consistent with §C of this regulation; Provide that an enrollee found to have abused pharmacy benefits will be enrolled in the program for 24 months; Provide that an enrollee who has been enrolled in a 24 month plan and is subsequently found to have abused MCO pharmacy benefits shall be enrolled in the plan for an additional 36 months; Provide for the MCO to select any participating pharmacy that meets the requirements of COMAR 10.09.75.02B(5)to serve as	Corrective Managed Care Plan Policies and Procedures Corrective Managed Care Plans Notices to and Correspondence with Enrollees Evidence of Record Reviews Completed by Licensed Medical Professionals	COMAR 10.67.12.02

		the enrollee's designated pharmacy provider for enrollees in corrective managed care; Require an enrollee to obtain prescribed drugs only from a single designated pharmacy provider, which may be any pharmacy or any single branch of a pharmacy chain that participates in the MCO and meets the requirements of COMAR 10.09.66.06B and .07C(2) unless the prescription is: (a) Pursuant to an emergency department visit; (b) Pursuant to hospital inpatient treatment; or (c) A specialty drug as defined in COMAR 10.09.67.04; Provide enrollees determined to have abused pharmacy benefits the ability to suggest pharmacy providers; Require the MCO to accept the enrollee's suggestion referenced in §B(7) of this regulation unless the MCO determines that the recipient's choice of provider would not serve the enrollee's best interest in achieving appropriate use of the health care systems and benefits available through the MCO; Provide an enrollee determined to have abused pharmacy benefits 20 days from the date of the notice to present additional documentation to explain		

		the facts that serve as the basis for the MCO's determination of benefit abuse, consistent with §D of this regulation; Provide for the designation of a new pharmacy provider if the enrollee moves out of the service area of the current pharmacy provider; Provide for prompt reporting to the Department the name of any enrollee enrolled in the MCO's program, the duration of enrollment, or any change in the duration of enrollment; and Be submitted to the Department for review and approval: (a) Within 60 days of the effective date of this regulation; and (b) Before the implementation of any modification.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The MCO must conduct a medical review which must: Be performed by a medical reviewer who is a licensed health care professional; Consider all information that is relevant and available to the MCO, including but not limited to MCO payment records and information secured from any interviews conducted; and Where appropriate, consider records obtained from other sources, including: (a) Providers of medical services; (b) Statistical reports; (c) Outside complaints; (d) Referrals from other agencies; or (e) Any other appropriate sources. If an enrollee provides additional information pursuant to §B(9) of this regulation within 20 days: The effective date of the enrollment provided in the notice shall be tolled pending the MCO's review of the additional information; The MCO shall consider whether the additional information changes the MCO's determination regarding the appropriateness of the enrollee's enrollment in corrective managed care;		

		The MCO shall notify the enrollee of its decision whether the MCO is affirming or reversing its determination to enroll the enrollee in corrective managed care; and If the MCO confirms its determination to enroll the enrollee in corrective managed care, the notice shall: (a) Identify the effective date and duration of that enrollment; and (b) Include an explanation of the enrollee's right to appeal the determination as described in Regulation .05 of this chapter. An MCO's corrective managed care plan may include a process for re-considering, at any interval of time, a decision to enroll an enrollee in the MCO's corrective managed care plan, if the process entitles the enrollee to appeal the decision pursuant to Regulation .05 of this chapter at the same interval of time.		
7.12	Deleted in CY 2019.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
8.0	Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management.			
8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM	The MCO must have policies and procedures in place to identify enrollees with special needs and/or complex health care needs,	CM Plan CM Criteria/ Standards CM Policies & Procedures	HCQIS XIV COMAR 10.67.03.06

	according to established criteria and must receive the appropriate services.	such as diabetes, severe asthma and high-risk pregnancy, and to enroll them into CM according to the MCOs established criteria. This system must allow the enrollee to access the appropriate services provided by the MCO. Per COMAR 10.09.65.04B, special needs populations are identified as: Children with special health care needs. Individuals with a physical disability. Individuals with a developmental disability. Pregnant and postpartum women. Individuals who are homeless. Individuals with HIV/AIDS. Children in State supervised care. Specifically, the MCO has documented evidence of the following: CM Plan that describes the MCO's CM program and/or CM policies and procedures. CM criteria and/or standards for the following: Identification of children and adult enrollees with special needs Assessments Plans of care Caseload Committee reporting structure.	CM Cases Committee Meeting Minutes (e.g., QA/UR) Job Descriptions Reports and Analysis Orientation/ Training Materials	COMAR 10.67.04.04-11 42 CFR §438.208(c)(1,2)

		Minimum qualifications for case managers and case manager supervisors. Orientation/Training for case managers. Number of FTEs allocated for CM.		
Standard	**Description**	**Review Guidelines**	**Documents to be Reviewed**	**Cite(s) and References**
8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.	There is documented evidence of HSNI: data collection methodology data analysis activities, and evidence that follow-up based on the results of the analysis is occurring in a timely manner. If MDH does not transmit health services needs information (HSNI) for an enrollee to the MCO within 10 calendar days of enrollment, the MCO shall make at least two attempts to conduct an initial screening of the enrollee's needs, within 90 calendar days of the effective date of enrollment. At least one of these attempts shall be during non-working hours. If the MCO does not receive the HSNI within the 10-day window, the MCO should attempt to perform the screening.	HSNI Policies and Procedures Reports and Analysis	COMAR 10.67.02.03
8.3	The MCO must have policies and procedures in place to coordinate care with primary care, Local Health	The MCO must have policies and procedures in place to assure the coordination of services for its enrollees, including	Continuity of Care Policies & Procedures	HCQIS XIV

	Departments (LHDs), school health programs, and other frequently involved community based organizations (CBOs).	coordination of care/services with the enrollee's PCP, LHDs (ACCU/Ombudsman, and transportation), school based health centers, and other CBOs where coordination with the MCO is necessary to ensure enrollee services are coordinated. Other CBOs might include Chase Brexton for HIV/AIDS, homes and domestic violence shelters, etc. Collaboration with other department activities such as quality and outreach.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
8.4	The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).	There is documented evidence of monitoring activities. This includes the collection and analysis of data.	Continuity of Care Policies & Procedures (e.g. hospitalizations, prenatal care) Data Analysis QA & UR Committee Meeting Minutes	HCQIS XI
8.5	The MCO must monitor the effectiveness of the CM Program.	Methodology to evaluate the effectiveness of the CM program. Methodology for monitoring the plans of care. Methodology for evaluating plans of care.	CM Evaluation Studies Analysis and Reports Computer Screen Shots of CM Software or Actual Demonstration of CM System Case Records	HCQIS XIV COMAR 10.67.03.06 COMAR 10.67.04.04-11

8.6	The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.	The MCO has policies and procedures for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation through documentation of coordination in enrollee records.	Coordination with Behavioral Health and Substance Use Vendors Policy and Procedures Enrollee Records	COMAR 10.67.04.14E
8.7	The MCO must comply with providing the Continuity of Health Care Notice to members and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by members.	The MCO has policies and procedures for complying with the Continuity of Health Care Notice and provides documentation of compliance. Evidence of compliance is not showing the Continuity of Health Care Notice in the Member Handbook. Examples of evidence may be derived from care management notes, documentation of single case agreements with out-of-network providers, member letters to show continued approval of a service received through an out-of-network provider, etc.	Policies and Procedures Care management notes, single case agreements with out-of-network providers, member letters	Ins. Art. §15-140(f)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.0	Health Education Plan – The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population. This standard will be reviewed until the MCO attains 100% compliance.			
9.1	The MCO has a comprehensive written HEP, which must include:	The MCO's HEP must contain all of the components listed in a-d.	HEP & Work Plan Health Education Schedule of Events	COMAR 10.67.04.03

	The education plan's purpose and objectives. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. A methodology for notifying enrollees and providers of available educational activities. A description of group and individual educational activities targeted at both providers and enrollees.	There must be an indication of how the objectives were established.	Health Education Materials Enrollee/Provider Notification Methodology	
9.2	The HEP incorporates activities that address needs identified through the analysis of enrollee data.	The MCO must provide evidence that enrollee data were analyzed to determine the need for certain health education programs.	HEP Enrollee Data Analysis Health Education Calendar of Events	COMAR 10.67.04.03
9.3	The MCO's HEP must: a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. c. Contain a provision addressing how the MCO will notify providers of the	The HEP must describe the qualifications of the staff that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietician, or certified mental health provider). The education plan must describe how a provider can access a health educator/ educational program through the MCO (e.g., the MCO may designate a contact person to assist the provider in connecting the enrollee to a health educator or program).	Data Analysis and Studies HEP and Work Plan Provider Manual Impact Evaluation Methodology	COMAR 10.67.04.03

	availability and contact information for accessing a health educator/educational program for member referrals.			
9.4	The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.	Mechanisms to identify enrollees in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one education of the enrollee with complex medical needs, the homebound enrollee, and the noncompliant enrollee with health issues.	Special Educational Need Identification Mechanisms	COMAR 10.67.04.03
9.5	The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide: a. Samples of notifications, brochures, and mailings. b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs.	The MCO must demonstrate that enrollees are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records and session evaluations. There must be evidence that providers are given the opportunity to evaluate enrollee educational sessions and the overall health education program.	Enrollee Mailings Attendance Records Completed Session Evaluations Program Evaluations Completed Provider Evaluations	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be reviewed	Cite(s) & References
10.0	Outreach Plan – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.			
10.1	The MCO has developed a written OP that describes the following: Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership. MCO's organizational capacity to provide both broad-based and enrollee-specific outreach. Unique features of the MCO's enrollee outreach initiatives. Community partnerships. Role of the MCO's provider network in performing outreach. MCO's relationship with each of the LHDs and ACCUs.	Each of the MCOs participating in HealthChoice is unique in the manner in which it facilitates the outreach requirements. The OP must describe the individual MCO's approach to providing outreach. This written plan must provide an overview of outreach activities that includes components 10.1a through 10.1f. Supporting policies and procedures must be in place to provide details regarding how these activities are carried out. The OP must include an overview of the populations to be served. At a minimum the populations must include: Those in need of wellness/ preventive services. Those children eligible for EPSDT services. Those enrollees (both adults and children) who are difficult to reach or miss appointments. Those enrollees comprising the following special populations defined in COMAR 10.09.65.04 B: Children with special health care needs.	• Educational Materials • DM and CM Program Descriptions • MOUs • Community Event Calendars or Education Program Schedules • Provider Manual • Provider Contracts • MOUs	COMAR 10.67.04.02

		Individuals with a physical disability. Individuals with a developmental disability. Pregnant and postpartum women. Individuals who are homeless. Individuals with HIV/AIDS. Children in State supervised care. The OP must briefly describe common health problems within the MCO's membership (i.e., diabetes, HIV/AIDS, pediatric asthma) and any identified barriers or specific areas where outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). The OP must provide an overview of how the MCO's internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, enrollee services, CM, DM, health education and delegated entities in the performance of outreach activities. The OP must briefly describe data management systems to be utilized in performing outreach activities. This may include data systems or software		

		used to identify, track, and report outreach activities. The OP briefly describes any unique educational activities related to the populations served, such as: Languages in which materials are printed and availability of interpreter services. TTD/TTY services for those who are hearing impaired. Any unique educational activities such as, CM or DM programs related to special populations (i.e., mother/baby programs, substance abuse programs for pregnant women, asthma management programs, etc.). Any other unique services related to education. The OP briefly describes any community partners and their role in providing outreach activities to assist the MCO in bringing enrollees into care (i.e., church groups, YMCA, homeless shelters, community based school programs, parks and recreation programs, medical societies and/or associations such as the American Diabetes Assoc., etc.). The community partner may provide educational health fairs or screenings, educational materials, speakers, personnel who assist the enrollee in completing		

		necessary medical paperwork or who assist the enrollee in locating special services to facilitate bringing the enrollee in to care, etc.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
10.2	The MCO has implemented policies and procedures for: a. The provision of outreach services for new and existing enrollees <u>for wellness/preventive health services.</u> b. <u>Deleted in CY 2019.</u> c. The provision of outreach via telephone, written materials, and face-to-face contact. d. Monitoring of all outreach activities, including those delegated or subcontracted to other entities.	There must be evidence that the MCO has policies and procedures implemented for each of the activities in 10.2 a-d. <u>The MCO identifies those enrollees in need of wellness/ preventive services and initiates activities to encourage utilization of these services. There is evidence that the MCO implements a system to track and monitor access to these services. For example, the MCO identifies and notifies enrollees of due dates for preventive services such as mammograms and cervical cancer screenings through reminder notices such as letters or postcards.</u> The MCO must have policies and procedures in place to guide outreach staff in the outreach process. This guidance may be in the form of policies and procedures or process flow charts. There must be evidence that	Data Reports Outreach Logs Enrollee Mailings Educational Materials LHD Reports	

		these processes are being followed. There must be evidence that the MCO utilizes a systematic process to provide outreach services that employs: Telephone contact. Written materials. Face-to-face contact. There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an agreement with the LHD to perform specific outreach activities such as face-to-face contact with enrollees, the MCO must have a mechanism for monitoring outcomes of these activities (i.e., number of enrollees referred for LHD outreach and number successfully reached).		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
11.0	Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.			
11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support	The MCO demonstrates the ability to detect and identify inappropriate and unlawful conduct, fraudulent activities, and abusive patterns through detailed	Compliance Plan Fraud Manual Fraud and Abuse Policies & Procedures	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15

	organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include: Documentation that articulates the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards. Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO's mandatory compliance plan. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and	policies, procedures, education and training. The MCO demonstrates the ability to internally monitor and audit for potential fraud and abuse in such areas as encounter data, claims submission, claims processing, billing procedures, underutilization, customer service, enrollment and disenrollment, marketing, and provider/enrollee education materials. The MCO documents its processes used to detect and identify incidences of fraud and abuse. The MCO documents its processes used to ensure services were actually provided to the enrollee. There must be evidence of the process such as policies and procedures, reports, trending, meeting minutes, studies, call scripts, data results, etc.	Compliance Officer Job Description and Qualifications Compliance Committee Membership Compliance Committee Meeting Minutes Communication Between Compliance Officer & Compliance Committee Routine and Random Audit Reports for Fraud and Abuse Reports tracking the receipt and dispensation of all incidences of reported suspected fraud and abuse	CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

	abuse education of MCO staff, enrollees, and providers. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation. A documented process to ensure that services billed to the MCO were actually received by the enrollee.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
11.2	The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include: Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse.	The MCO demonstrates clear and well-publicized communication of disciplinary guidelines to employees, subcontractors of the MCO, and enrollees to sanction fraud and abuse offenses. The MCO demonstrates its process exists, e.g. a hotline, which allows employees, subcontractors of the MCO, and enrollees to report suspected fraud and abuse without fear of reprisal. The MCO will also demonstrate its procedures for timely investigation, dispensation, and tracking of reported suspected incidences of fraud and abuse.	Compliance Plan Fraud Manual Fraud and Abuse Policies & Procedures Staff orientation, education, and training protocols pertaining to fraud and abuse Sign-in rosters for employee training sessions regarding fraud and abuse	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

	A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees. A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse. A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse. A documented process for enforcement of standards through clear communication of well-publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse. A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal.			

	A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal. A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
11.3	The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include: A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report. A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid	The MCO documents its processes for reporting and tracking suspected incidences of fraud and abuse to the appropriate State and Federal agencies within the appropriate time frames and its cooperation with those agencies investigating those alleged incidences.	Compliance Plan Fraud Manual Fraud and Abuse Policies & Procedures Documentation of reported incidences of fraud and abuse to State Medicaid Agency Documentation of collaboration and cooperation with State Medicaid Fraud Control Unit	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

	Fraud Control Unit when suspected fraud and abuse is investigated.			
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP. Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud	The MCO documents the mechanisms that evaluate the effectiveness of its fraud and abuse compliance plan through routine and random reports, CAPs and their implementation, administrative and management procedures. The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.	Compliance Committee Minutes Routine and Random Fraud and Abuse Reports CAPs CAP Implementation Reports Delegate Fraud and Abuse Reports	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

	and abuse activities, as specified in 11.1d.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
11.5 (Formerly 2.8)	An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity. An MCO must have written policies and procedures ensuring	An MCO may not have a relationship with an individual or entities who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. An MCO may not have an affiliation with an individual or entities who have been debarred by Federal Agencies, as defined in the Federal Acquisition Regulation. Initial checks of all databases are required. Monthly checks of the following databases are required: List of Excluded Individuals/Entities and Excluded Parties List Systems/SAM.	Governance Policies and Procedures Subcontracting and Employment Policies and Procedures Evidence of data checks	42 CFR § 438.610(a) 42 CFR § 438.610(b) 42 CFR § 438.610(c) COMAR 10.67.03.03 42 CFR § 455.436 COMAR 10.67.07.03G

	that it does not have an individual or entities debarred by Federal Agencies with an employment, consulting or other arrangement with the MCO. An MCO must provide evidence of initial and monthly checks of the following databases as applicable: Social Security Death Master File; National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/SAM. An MCO must have written policies and procedures for providing written disclosure of any prohibited affiliation and/or termination to MDH.			

Appendix 6. – Consumer Report Card Methodology

Introduction

As a part of its External Quality Review contract with the Maryland Department of Health (MDH), Qlarant is responsible for developing a Medicaid Consumer Report Card.

The Report Card is meant to help Medicaid participants select a HealthChoice managed care organization (MCO). Information in the Report Card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS®[1]), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) survey, and Maryland's encounter data measures.

This report explains the reporting strategy and analytic methods Qlarant will use in developing the Report Card that the MDH will release in 2020, based on data reported from the MCOs in CY 2019. This report is organized as follows:

> ***Section II: Information Reporting Strategy*** explains the principles used to determine the most appropriate and effective methods of reporting quality information to Medicaid participants, the intended target audience.
>
> ***Section III: Analytic Method*** provides statistical basis and the analysis method to be used for reporting comparative MCO performance.
>
> ***Appendices*:**
> *A.* Reporting Categories and Measures
> *B.* Questions Comprising CAHPS Measures for the Medicaid Product Line
> *C.* Statistical Methodology to Compare MCO Performance

Information Reporting Strategy

The most formidable challenge facing all consumer information projects is how to communicate a large amount of complex information in an understandable and meaningful manner, while fairly and accurately representing the data. In determining the appropriate content for Maryland's HealthChoice Report Card, principles were identified that addressed these fundamental questions:

- Is the information meaningful for the target audience?
- Will the target audience understand what to do with the information?
- Are the words or concepts presented at a level that the target audience is likely to understand?
- Does the information contain an appropriate level of detail?

The reporting strategy presented incorporates methods and recommendations based on experience and research about presenting quality information to consumers.

Organizing Information

Group relevant information in a minimal number of reporting categories and in single-level summary scores.

---

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2]CAHPS® is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

Recommendation—To enhance comprehension and interpretation of quality measurement information provided for a Medicaid audience, the Qlarant team will design the Report Card to include six categories, with one level of summary scores (measure roll-ups) per MCO, for each reporting category.

Rationale—Research has shown that people have difficulty comparing MCO performance when information is presented in too many topic areas. To include a comprehensive set of performance measures in an effective consumer-information product (one that does not present more information than is appropriate for an audience of Medicaid participants), measures must be combined into a limited number of reporting categories that are meaningful to the target audience.

Group measures into reporting categories that are meaningful to consumers.

Recommendation—Based on a review of the potential measures available for the Report Card (HEDIS, CAHPS, and Maryland's encounter data measures), the team recommends the following reporting categories:

- Access to Care
- Doctor Communication and Service
- Keeping Kids Healthy
- Care for Kids With Chronic Illness
- Taking Care of Women
- Care for Adults With Chronic Illness

Rationale—The recommended categories are based on measures reported by HealthChoice MCOs in 2018 and designed to focus on clearly identifiable areas of interest. Consumers may focus on MCO performance in the areas most important to them and their families.

The first two categories are relevant to all participants; the remaining categories are relevant to specific Maryland HealthChoice participants: children, children with chronic illness, women, and adults with chronic illness.

Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

MEASURE SELECTION

Select measures that apply to project goals.

The measures that the project team considered for inclusion in the Report Card are derived from those that MDH requires MCOs to report, which include HEDIS measures; the CAHPS results from both the Adult Questionnaire and the Child Questionnaire; and MDH's encounter data measures.

Each year, the team has created measure selection criteria that has a consistent and logical framework for determining which quality of care measures are to be included in each composite.

- **Meaningful.** Do results show variability in performance in order to inform health care choices?
- **Useful.** Does the measure relate to the concerns of the target audience?
- **Understandable.** Are the words or concepts presented in a manner that the target audience is likely to understand?

Appendix A includes the complete list of HEDIS, CAHPS, and Maryland encounter data measures recommended for inclusion in each reporting category.

HEDIS Measures

Summary of HEDIS 2019 Measure Changes

The following Measure Specification and HEDIS General Updates do not affect the Report Card methodology. For detailed changes, refer to *HEDIS 2019, Volume 2: Technical Specifications for Health Plans.*

Measure Specific Updates

- *Breast Cancer Screening*:
  - No changes.

- *Appropriate Testing for Children With Pharyngitis*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Immunizations for Adolescents*:
  - Added optional exclusions for Tdap.

- *Appropriate Treatment for Children With Upper Respiratory Infection*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Controlling High Blood Pressure*:
  - Revised the definition of representative Blood Pressure (BP) to indicate the BP reading must occur on or after the second diagnosis of hypertension.
  - Removed the diabetes flag identification form the event/diagnosis criteria.
  - Added administrative method for reporting.
  - Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
  - Updated the Hybrid specification to indicate that sample size reduction is not allowed.
  - Removed the requirement to confirm the hypertension diagnosis.
  - Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

- *Comprehensive Diabetes Care*
  - Added telehealth into the measure specifications.

- Added methods to identify bilatrerial eye enucleation.
- Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
- Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

HEDIS 2019 General Updates

- Telehealth is incorporated into several measures.
- Certified Federally Qualified Health Centers (FQHC) are considered PCPs. Certification must be reviewed and approved by an auditor**.**

CAHPS Patient Experience Survey Measures

Consistent with the 2019 Consumer Report Card, it is recommended that results of both the CAHPS Health Plan Survey 5.0H, Adult Version and the CAHPS Health Plan Survey 5.0H, Child Version with the Children With Chronic Conditions (CCC) measures be included.

The sampling protocol for the CAHPS 5.0H Child Questionnaire allows reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic illness. For each population, results include the same ratings, composites, and individual question summary rates. In addition, five CCC measures are reported for the population of children with chronic illness.

Appendix B shows the questions comprising the CAHPS 5.0H measures recommended for the Report Card and their score values.

Summary of CAHPS Measure Changes for 2019

- No modifications were made to the CAHPS Survey for CY 2019

Overall Reporting Category Changes for 2020 Report Card

- Access to Care
  - No changes
- Doctor Communication and Service
  - No changes
- Keeping Kids Healthy
  - No changes
- Care for Kids with Chronic Illness
  - No changes
- Taking Care of Women
  - No changes
- Care for Adults With Chronic Illness

- No changes

FORMAT

Display information in a format that is easy to read and understand.

The following principles are important when designing Report Cards:

- *Space:* Maximize the amount to display data and explanatory text.
- *Message:* Communicate MCO quality in positive terms to build trust in the information presented.
- *Instructions:* Be concrete about how consumers should use the information.
- *Text:* Relate the utility of the Report Card to the audience's situation (e.g., new participants choosing an MCO for the first time, participants receiving the Annual Right to Change Notice and prioritizing their current health care needs, current participants learning more about their MCO) and reading level.
- *Narrative:* Emphasize *why* what is being measured in each reporting category is important, rather than giving a detailed explanation of *what* is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens…"
- *Design:* Use color and layout to facilitate navigation and align the star ratings to be left justified ("ragged right" margin), consistent with the key.

Recommendation—An 11 x 18-inch, one page document, with English on one side and Spanish on the opposite side. This one-page document allows presentation of all information. Measure explanations can be integrated on the same page as performance results, helping readers match the explanation to the data.

Draft document contents at a sixth-grade reading level, with short, direct sentences intended to relate to the audience's particular concerns. Avoid terms and concepts unfamiliar to the general public. Explanations of performance ratings, measure descriptions, and instructions for using the Report Card will be straightforward and action-oriented. Translate contents into Spanish using an experienced translation vendor.

***Rationale*—**Cognitive testing conducted for similar projects showed that Medicaid participants had difficulty associating data in charts with explanations if they were presented elsewhere in the Report Card. Consumers prefer a format that groups related data on a single page. Given the number of MCOs whose information is being presented in Maryland's HealthChoice Report Card, a one-page document format will allow easy access to information.

RATING SCALE

Rate MCOs on a tri-level rating scale.

***Recommendation*—**Compare each MCO's performance with the average of all MCOs potentially available to the target audience; in this case, the average of all HealthChoice

MCOs ("the Maryland HealthChoice MCO average"). Use stars or circles to represent performance that is "above," "the same as" or "below" the Maryland HealthChoice MCO average.

***Rationale*—**A tri-level rating scale in a matrix that displays performance across selected performance categories provides participants with an easy-to-read "picture" of quality performance across plans and presents data in a manner that emphasizes meaningful differences between MCOs that are available to them. (Refer to *Section III: Analytic Method*.) This methodology differs from similar methodologies that compare MCO performance with ideal targets or national percentiles. This approach is more useful in an environment where consumers must choose from a group of MCOs.

At this time, developing an overall rating for each MCO is not recommended. The current reporting strategy allows Report Card users to decide which performance areas are most important to them when selecting an MCO.

Analytic Method
The Report Card compare each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average.[3]

The goal of analysis is to generate reliable and useful information that can be used by Medicaid participants to make relative comparisons of the quality of health care provided by Maryland's HealthChoice MCOs. Information should allow consumers to easily detect differences in MCO performance. The index of differences should compare MCO-to-MCO quality performance directly, and the differences between MCOs should be statistically reliable.

Handling Missing Values

Replacing missing values can create three issues. Analysts need to first decide which pool of observed (nonmissing) MCOs should be used to derive replacement values for missing data and thendecide how imputed values will be chosen. Alternatives are fixed values (such as "zero" or "the 25th percentile for all MCOs in the nation"), calculated values (such as means or regression estimates), or probable selected values (such as multiplying imputed values). Finally, analysts determine the method used to replace missing values; one that should not provide an incentive for poorly performing plans to intentionally fail to report data. For example, if missing values are replaced with the mean of nonmissing cases, scores for MCOs that perform below the mean would be higher if they fail to report.

[3] For state performance reports directed at participants, NCQA believes it is most appropriate to compare an MCO's performance with the average of all MCOs serving the state. NCQA does not recommend comparing MCOs with a statewide average that has been weighted proportionally to the enrollment size of each MCO. A weighted average emphasizes MCOs with higher enrollments and is used to measure the overall statewide average. Report cards compare a MCO's performance relative to other MCOs, rather than presenting how well the state's Medicaid MCOs serve participants *overall*. In a Report Card, each MCO represents an equally valid option to the reader, regardless of enrollment size.

Replacing missing Medicaid MCO data with commercial plan data is inappropriate because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to national Medicaid plans, regional Medicaid MCOs, or Maryland HealthChoice MCOs. Analyses conducted by NCQA for the annual *State of Health Care Quality Report* have consistently shown substantial regional differences in performance of commercial managed care plans. Assuming that regional differences generalize to Medicaid MCOs, it would be inappropriate to use the entire group of national Medicaid MCOs to replace missing values for Maryland HealthChoice MCOs.

Using a regional group of MCOs to derive missing values was determined to be inappropriate also because of substantial differences in Medicaid program administration across states. In other words, reporting of Medicaid data is skewed to a few large states with large Medicaid managed care enrollment.

For these reasons, Maryland HealthChoice MCOs should serve as the pool from which replacement values for missing data are generated. A disadvantage to using only Maryland HealthChoice MCOs for missing data replacement is that there are fewer than 20 MCOs available to derive replacement values. Data-intensive imputation procedures, such as regression or multiple imputations, are unlikely to be employed.

MCOs are sometimes unable to provide suitable data (for example, if too few of their members meet the eligibility criteria for a measure), despite their willingness to do so. These missing data are classified as "Not Applicable" (NA).

- For HEDIS, health plans that followed the specifications but had too small a denominator (<30) to report a valid rate are assigned a measure result of NA.
- For CAHPS, MCOs must achieve a denominator of at least 100 responses to obtain a reportable result. MCOs whose denominator for a survey result calculation is <100 are assigned a measure result of NA.

If the NCQA HEDIS Compliance Audit™ finds a measure to be materially biased, the HEDIS measure is assigned a " Biased Rate" (BR) and the CAHPS survey is assigned "Not Reportable" (NR). For Report Card purposes, missing values for MCOs will be handled in this order:

- If fewer than 50 percent of the MCOs report a measure, the measure is dropped from the Report Card category.
- If an MCO has reported at least 50 percent of the measures in a reporting category, the missing values are replaced with the mean or minimum values, based on the reasons for the missing value.
- MCOs missing more than 50 percent of the measures composing a reporting category are given a designation of "Insufficient Data" for the measurement category.

Calculations in each category are based on the remaining reportable measures versus reportable MCOs. "NA" and "BR/NR" designations will be treated differently where values are missing. "NA" values will be replaced with the *mean* of nonmissing observations and "BR/NR" values will be replaced with the *minimum value* of nonmissing observations. This minimizes any disadvantage to MCOs that are willing to report data but are unable to. Variances for replaced rates are calculated differently for CAHPS survey measures and for nonsurvey measures (HEDIS, Maryland encounter data). Refer to Appendix C for details.

Handling New MCOs

MCOs are eligible for inclusion in the star rating of the report card when they are able to report the required HEDIS and CAHPS measures according to the methodology outlined in this Information Reporting Strategy and Methodology document set forth by the Department.

Members Who Switch Products/Product Lines

Per HEDIS guidelines, members who are enrolled in different products or product lines in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the

continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS report.

Members who "age in" to a Medicare product line mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., commercial) during the continuous enrollment period and their enrollment did not exceed allowable gaps. The organization must use claims data from all products/product lines, even when there is a gap in enrollment.

Case-Mix Adjustment of CAHPS Data

Several field-tests indicate a tendency for CAHPS respondents in poor health to have lower satisfaction scores. It is not clear whether this is because members in poor health experience lower-quality health care or because they are generally predisposed to give more negative responses (the halo effect).

It is believed that respondents in poor health receive more intensive health care services—and their CAHPS responses do contain meaningful information about the quality of care delivered in this more intensive environment; therefore, case-mix adjusting is not planned for the CAHPS data used in this analysis.

Statistical Methodology

Appendix C presents the statistical methodology, which includes the following steps:

1. Create standardized versions of all measures for each MCO so that all component measures contributing to the summary scores for each reporting category are on the same scale. Measures are standardized by subtracting the mean of all MCOs from the value for individual MCOs and dividing by the standard deviation of all MCOs.
2. Combine the standard measures into summary scores in each reporting category for each MCO.
3. Calculate standard errors for individual MCO summary scores and for the mean summary scores for all MCOs.
4. Calculate difference scores for each reporting category by subtracting the mean summary score for all MCOs from individual MCO summary score values.
5. Use the standard errors to calculate 95 percent confidence intervals (CI) for the difference scores.
6. Categorize MCOs into three categories on the basis of these Cis:
    - If the entire 95 percent CI is in the positive range, the MCO is categorized as "above average."
    - If an MCO's 95 percent CI includes zero, the MCO is categorized as "average."
    - If the entire 95 percent CI is in the negative range, the individual MCO is categorized as "below average."

This procedure generates classification categories, so differences from the group mean for individual MCOs in the "above average" and "below average" categories are statistically significant at $\alpha = .05$. Scores of MCOs in the "average" category are not significantly different from the group mean.

Quality Control

Qlarant includes quality control processes for ensuring that all data in the Report Card are accurately presented. This includes closely reviewing the project's agreed upon requirements and specifications of each measure so that impacts of any changes are assessed and clearly delineated, and cross-checking all

data analysis results against two independent analysts. Qlarant will have two separate programmers independently review the specifications and code the Report Card. The analysts will both complete quality reviews of the data, discuss and resolve any discrepancies in analysis. Following the quality control processes, Qlarant will deliver the data analysis necessary to support public reporting in the Report Card.

Reporting Categories and Measures

CATEGORY: ACCESS TO CARE	DATA SOURCE	WEIGHT
Getting Needed Care (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Getting Care Quickly (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Customer Service (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Children and Adolescents' Access to Primary Care Practitioners (12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12-19 years)	HEDIS	1/7
Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years and 45 to 64 years)	HEDIS	1/7
Access to Care - SSI Adult (21 years or older)*	MDH Encounter Data	1/7
Access to Care – SSI Children (ages 0-20)*	MDH Encounter Data	1/7
CATEGORY: DOCTOR COMMUNICATION AND SERVICE	**DATA SOURCE**	**WEIGHT**
Rating of All Health Care (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Personal Doctor (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Specialist Seen Most Often (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
How Well Doctors Communicate (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Shared Decision Making ("Yes" composite global proportion^)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Health Promotion and Education ("Yes" question summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Coordination of Care ("Usually" and "Always" question summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
CATEGORY: KEEPING KIDS HEALTHY	**DATA SOURCE**	**WEIGHT**
Childhood Immunization Status (Combo 3)*	HEDIS	1/8
Appropriate Treatment for Children With Upper Respiratory Infections (3 months-18 years)	HEDIS	1/8
Appropriate Testing for Children With Pharyngitis (2-18 years)	HEDIS	1/8
Well-Child Visits in the First 15 Months of Life (6+ visit rate)	HEDIS	1/8
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*	HEDIS	1/8
Adolescent Well-Care Visits (12-21 years)*	HEDIS	1/8
Lead Screening (12 through 23 months)*	MDH Encounter Data, MDE Lead Registry, FFS Data	1/8

Immunization for Adolescents (Combo 1)*	HEDIS	1/8

*Maryland Value-Based Purchasing measure
^Note this composite should be calculated using Composite Global Proportion instead of the Composite Mean.

CATEGORY: CARE FOR KIDS WITH CHRONIC ILLNESS	DATA SOURCE	WEIGHT
Access to Prescription Medicines (question mean)	CAHPS 5.0H MC	1/6
Access to Specialized Services: Special Medical Equipment or Devices (composite mean)	CAHPS 5.0H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ("Yes" composite global proportion)	CAHPS 5.0H MC	1/6
Family Centered Care: Getting Needed Information (question mean)	CAHPS 5.0H MC	1/6
Coordination of Care for Children With Chronic Conditions ("Yes" composite global proportion)	CAHPS 5.0H MC	1/6
Asthma Medication Ratio [5-18 years (combine 5-11 years and 12-18 years)]*	HEDIS	1/6
CATEGORY: TAKING CARE OF WOMEN	**DATA SOURCE**	**WEIGHT**
Breast Cancer Screening*	HEDIS	1/5
Cervical Cancer Screening	HEDIS	1/5
Chlamydia Screening (Total Rate: 16-24 years)	HEDIS	1/5
Timeliness of Prenatal Care	HEDIS	1/5
Postpartum Care*	HEDIS	1/5
CATEGORY: CARE FOR ADULTS WITH CHRONIC ILLNESS	**DATA SOURCE**	**WEIGHT**
CDC: Hemoglobin A1c (HbA1c) Testing*	HEDIS	1/8
CDC: HbA1c Poor Control (>9.0%) Note: MCO rate used in the analysis is the inverse score, in order to provide consistency with other measures (i.e. higher % is better)	HEDIS	1/8
CDC: Eye Exam (Retinal) Performed	HEDIS	1/8
CDC: Medical Attention for Nephropathy	HEDIS	1/8
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	HEDIS	1/8
Use of Imaging Studies for Low Back Pain	HEDIS	1/8
Asthma Medication Ratio [19-64 years (combine 19-50 years and 51-64 years)]*	HEDIS	1/8
Controlling High Blood Pressure*	HEDIS	1/8

CAHPS 5.0H Measures for the Medicaid Product Line

The table below displays the questions, response choices and corresponding score values used to calculate results for the CAHPS 5.0H Adult Questionnaire and Child Questionnaire [With Children with Chronic Conditions measure (CCC)]. The sampling protocol for the Child Questionnaire allows for the reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic conditions.

Question	Getting Needed Care	Response Choices	Score Values
Q25=MA **Q46=MC**	In the last 6 months, how often was it easy to get appointments with specialists?	Never Sometimes Usually Always	1 1 2 3

Q14=MA **Q15=MC**	In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	Never Sometimes Usually Always	1 1 2 3
Question	**Getting Care Quickly**	**Response Choices**	**Score Values**
Q4=MA **Q4=MC**	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	Never Sometimes Usually Always	1 1 2 3
Q6=MA **Q6=MC**	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Never Sometimes Usually Always	1 1 2 3
Question	**How Well Doctors Communicate**	**Response Choices**	**Score Values**
Q17=MA **Q32=MC**	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	Never Sometimes Usually Always	1 1 2 3
Q18=MA **Q33=MC**	In the last 6 months, how often did your personal doctor listen carefully to you?	Never Sometimes Usually Always	1 1 2 3

Key:
MA = CAHPS 5.0H Medicaid Adult Questionnaire
MC = CAHPS 5.0H Medicaid Child Questionnaire (With CCC measure)

Question	How Well Doctors Communicate	Response Choices	Score Values
Q19=MA Q34=MC	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never Sometimes Usually Always	1 1 2 3
Q20=MA Q37=MC	In the last 6 months, how often did your personal doctor spend enough time with you?	Never Sometimes Usually Always	1 1 2 3
Question	**Customer Service**	**Response Choices**	**Score Values**
Q31=MA Q50=MC	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	Never Sometimes Usually Always	1 1 2 3
Q32=MA Q51=MC	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never Sometimes Usually Always	1 1 2 3
Question	**Shared Decision Making**	**Response Choices**	**Score Values**
Q10=MA Q11=MC	Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?	Yes No	1 0
Q11=MA Q12=MC	Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?	Yes No	1 0
Q12=MA Q13=MC	When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	Yes No	1 0
Question	**Health Promotion and Education**	**Response Choices**	**Score Values**
Q8=MA Q8=MC	In the last 6 months, did you and a doctor or other health provider talk specific things you could do to prevent illness?	Yes No	1 0
Queston	**Coordination of Care**	**Response Choices**	**Score Values**
Q22=MA Q40=MC	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	Never Sometimes Usually Always	0 0 1 1

Question	Rating of Health Care	Response Choices	Score Values
Q13	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	0>=Q13<=6 Q13>=7<=8 Q13>=9<=10	1 2 3
Q14	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?	0>=Q14<=6 Q14>=7<=8 Q14>=9<=10	1 2 3
Question	**Rating of Personal Doctor**	**Response Choices**	**Score Values**
Q23	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	0>=Q23<=6 Q23>=7<=8 Q23>=9<=10	1 2 3
Q41	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?	0>=Q41<=6 Q41>=7<=8 Q41>=9<=10	1 2 3
Question	**Rating of Specialist**	**Response Choices**	**Score Values**
Q27	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	0>=Q27<=6 Q27>=7<=8 Q27>=9<=10	1 2 3
Q48	We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	0>=Q48<=6 Q48>=7<=8 Q48>=9<=10	1 2 3

Key:
MA = CAHPS 5.0H Medicaid Adult Questionnaire
MC = CAHPS 5.0H Medicaid Child Questionnaire (With CCC measure)

CAHPS 5.0H Child Questionnaire Measures

The following questions from the CAHPS 5.0H Child Questionnaire provide information on parents' experience with their child's health plan for the population of children with chronic conditions. The five CCC measures summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions. The child is included in the CCC population calculations if one or more of the following survey-based screening criteria are true:

- Child currently needs/uses **medicine prescribed by a doctor** for a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child needs/uses more **medical, mental health or educational services** than is usual for most children the same age due to a medical, behavioral or other health condition lasting/ expected to last 12 months or more.
- Child is **limited or prevented** in any way in his or her ability to do the things most children of the same age can do because of a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child needs to get **special therapy**, such as physical, occupational or speech therapy for a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child has any kind of emotional, developmental or behavioral problem lasting/expected to last 12 months or more for which he or she needs or gets **treatment or counseling**.

Question	Access to Prescription Medicines	Response Choices	Score Values
Q56	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?	Never Sometimes Usually Always	1 1 2 3
Question	**Access to Specialized Services**	**Response Choices**	**Score Values**
Q20	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never Sometimes Usually Always	1 1 2 3
Q23	In the last 6 months, how often was it easy to get this therapy for your child?	Never Sometimes Usually Always	1 1 2 3
Q26	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never Sometimes Usually Always	1 1 2 3

Question	Family-Centered Care: Personal Doctor Who Knows Child	Response Choices	Score Values
Q38	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	Yes No	1 0
Q43	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	Yes No	1 0
Q44	Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	Yes No	1 0
Question	**Family-Centered Care: Getting Needed Information**	**Response Choices**	**Score Values**
Q9	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	Never Sometimes Usually Always	1 1 2 3
Question	**Coordination of Care for Children With Chronic Conditions**	**Response Choices**	**Score Values**
Q18	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	Yes No	1 0
Q29	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	Yes No	1 0

Statistical Methodology to Compare Plan Performance

The analysts will compute a series of summary measure scores for each MCO, including the summary mean values for the MCOs as a group. Higher values represent better performance.[1] The summary scores are calculated from MCO scores on selected HEDIS measures, CAHPS questions and composites, and additional data from the Maryland HealthChoice Program.

Prior to statistical analysis, Qlarant reviews the data for missing values. MCOs with more than half of the measures missing in a summary category do not receive a summary score for that category. Otherwise, missing values will be handled as follows:

- Rates with an "BR/NR" (Biased Rate/Not Reportable) designation are assigned the minimum plan rate.
- Rates with an "NA" (Not Applicable) designation are assigned the average MCO rate.

[1] For HbA1c Poor Control (>9.0%), the rate used in analysis is the inverse of the plan rate, for consistency with other measures (i.e., higher percentage is better).

For HEDIS and Maryland encounter data measures, the variances of the missing values are calculated from the replaced rates using the standard formula for proportions, p: p*(1-p)/(n-1), where the value of n is set to the default sample size (411) for the Hybrid collection method.

Because many CAHPS measures are composites or means, it is not possible to calculate their variance from the replaced rates; therefore, for all CAHPS measures—whether they are rating means, composite means, global proportions or summary rates—the missing variances are also replaced by the average (NA) or minimum (BR/NR) variance of the other MCOs.

Default variances specified for CAHPS Rating Means and Rating Question Summary Rates in *HEDIS Volume 3: Specifications for Survey Measures* are the variances in the distribution of member answers. These must be divided by the number of members to arrive at the variance of the mean.

For all other CAHPS measures, HEDIS Volume 3 specifies the variance of the mean. It is the variance of the mean that is replaced for a measure with an NA or BR/NR designation.
For Report Card purposes, missing values for MCOs are handled in this order:

- If fewer than 50 percent of the MCOs report a measure, the measure is dropped from the Report Card category.
- If a MCO has reported at least 50 percent of the measures in a reporting category, the missing values are replaced with the mean or minimum values, based on the reasons for the missing value.
- MCOs missing >50 percent of the measures composing a reporting category are given a designation of "Insufficient Data" for the measurement category.

For HbA1c Poor Control (>9.0%), the rate used in analysis is the inverse of the plan rate, for consistency with other measures (i.e., higher percentage is better).

- If a new plan has insufficient data in either HEDIS or CAHPS categories, or combined lack of measures to report (NAs or NRs) then that new plan should be excluded from the evaluation.

Calculations in each category are based on the remaining reportable measures vs. reportable MCOs.

MCO ratings are based on the difference between the MCO score and the unweighted group mean. The statistical significance of each difference is determined by computing a confidence interval (CI) around it. The formulas below assume a 95 percent CI. MCOs with differences significantly above or below zero receive the top and bottom designations, respectively. A MCO is significantly above zero if the lower limit of the CI is greater than zero; it is significantly below zero if the upper limit of the CI is below zero. All remaining plans receive the middle designation.

The specific formula for calculating the CI around a summary score is based on the CI formulas for the individual measures that compose the summary measure. These are presented first. The formulas can be modified to incorporate variable weights for the measures. The formulas presented here assume that each measure receives equal weight.

Specific Methods

1. For an individual HEDIS measure score, the CI formula is as follows:
   For a given measure and MCO k, let the difference d_k = MCO k score – group mean.

   The formula for the 95% CI is:

   95% CI $\quad d_k \pm 1.96\sqrt{Var(d_k)}$

   where $Var(d_k)$ = Variance of d_k is estimated as $\frac{N(N-2)}{N^2} * \frac{p_k(1-p_k)}{n_k - 1} + \frac{1}{N^2}\sum_{k=1}^{N}\frac{p_k(1-p_k)}{n_k - 1}$

   and: p_k = MCO k score

   N = total number of MCOs

   n_k = number of members in the measure sample for MCO k.

   The CIs for CAHPS question means, CAHPS composites and the summary measures are computed similarly by modifying the formula for $Var(d_k)$ to take into account the variances of the HEDIS scores, CAHPS questions and CAHPS composites in each summary measure.

2. For summary measures that include HEDIS measures only (i.e. all measures are proportions), first standardize each measure score in the summary by subtracting the group mean and dividing by the group standard deviation. Sum the MCO standardized scores to get the MCO summary measure score. Use these scores to compute the group summary mean and the difference scores.

   For each MCO k, substitute $\sum_{j=1}^{m}\frac{w_j^2}{s_j^2}\frac{p_j(1-p_j)}{n_j - 1}$ for $p_k(1-p_k)/(n_k-1)$ in the variance formula where:

   j = 1,…, m HEDIS measures in the summary measure

   n_j = number of members in the denominator for measure j

   s_j = standard deviation for measure j

w_j = weight for measure j scaled so that $\sum_{j=1}^{m} w_j = 1$

p_j = nonstandardized MCO score for measure j

3. For individual CAHPS ratings' questions, convert each question response to a score (1, 2, 3) and compute the MCO mean. Use the MCO means to compute the group mean and the difference scores.

   Next substitute $\frac{1}{n_k}\frac{\sum_{i=1}^{n_k}(x_i - \bar{x})^2}{n_k - 1}$ for $p_k(1-p_k)/(n_k-1)$ in the variance formula where:

   x_i = response of member i

   $\bar{x}$ = the mean score for MCO k

   n_k = number of responses in MCO k.

4. For CAHPS composites, convert each individual response to a score (1, 2, 3) and calculate each MCO composite mean as described in HEDIS Volume 3. Use the MCO composite means to compute the group mean and the difference scores. Substitute CV_k , the MCO k Composite Variance, for $p_k(1-p_k)/(n_k-1)$ in the variance formula where:

$$CV_k = \frac{T}{T-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij} - \bar{x}_j)}{n_j}\right)^2$$

   and:

   j = 1,…, m questions in the composite measure

   i = 1,…, nj members responding to question j

   x_{ij} = response of member i to question j (1, 2, 3)

   $\bar{x}_j$ = MCO mean for question j

   T = number of members responding to at least one question in the CAHPS composite.

For the summary measures that include CAHPS scores only (individual questions or composites), first convert each individual response to a score (1-3 or 0-1) as described in HEDIS Volume 3. Compute the MCO mean for each individual rating's question in the summary measure and the MCO composite mean for each composite. Next, standardize each MCO mean (individual question or composite) by subtracting the mean of the MCO

5. means and dividing by the standard deviation of the MCO means. Compute the sum of the standardized MCO means to get the MCO summary measure score. Use these summary scores to compute the group mean and the difference scores.

   For each MCO k, substitute: $\sum_{j=1}^{m_c}\frac{w_j^2}{s_j^2}CV_j + \sum_{j=1}^{m_q}\frac{w_j^2}{s_j^2}\frac{1}{n_j}\frac{\sum_{i=1}^{n_j}(x_{ij} - \bar{x}_j)^2}{n_j - 1}$ for $p_k(1-p_k)/(n_k-1)$

   in the variance formula, where:

   j = 1,…, m_c or m_q composites or questions in the summary measure

s_j = standard deviation for composite or question j

w_j = weight for measure j scaled so that $\sum_{j=1}^{m} w_j = 1$

CV_j = composite variance for composite j

x_{ij} = response of member i to question j (1, 2, 3)

$\bar{x}_j$ = nonstandardized MCO mean score for question j

n_j = number of responses to question j

6. For the summary measures that include HEDIS and CAHPS scores, the variance of the summary measure is the sum of the variances of the components of the measure. Score each CAHPS question or composite by converting each individual response to a score (1, 2, 3) as described in HEDIS Volume 3. Compute the MCO composite mean for each CAHPS composite and the MCO mean for each HEDIS measure or CAHPS question.

Next, standardize each MCO mean (composite or HEDIS) by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means. Compute the sum of the standardized MCO means to get the MCO summary measure score. Use the summary scores to compute the group mean and the difference scores.

For each MCO k, substitute: $\sum_{j=1}^{m_c} \frac{w_j^2}{s_j^2} CV_j + \sum_{j=1}^{m_q} \frac{w_j^2}{s_j^2} \frac{1}{n_j} \frac{\sum_{i=1}^{n_j} (x_{ij} - \bar{x}_j)^2}{n_j - 1} + \sum_{j=1}^{m} \frac{1}{s_j^2 w_j^2} \frac{p_j(1-p_j)}{n_j - 1}$

for $p_k(1-p_k)/(n_k-1)$ in the variance formula where:

j = 1,…, m or m_c or m_q HEDIS measures or CAHPS composites or CAHPS questions in the summary

n_j = number of members in the sample or denominator for measure j

x_{ij} = response of member i to question j (1, 2, 3)

$\bar{x}_j$ = non-standardized MCO mean for question j

CV_j = composite variance for composite j

s_j = standard deviation for measure j

w_j = weight for measure j scaled so that $\sum_{j=1}^{m} w_j = 1$

p_j = nonstandardized MCO score for measure j